

Running Head: Comparison of Oversight Models in Managed Care

A Comparison of the Audit and Accreditation Tools Used By
The Health Care Financing Administration, The Texas Department of Insurance, and
The National Committee on Quality Assurance:
The Cost of Multi-Agency Oversight on Medicare+Choice Plans in Texas

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Abstract

On 1 January 2001, approximately 711,000 Medicare patients lost their Medicare+Choice (M+C) health maintenance organization (HMO) provider. The costly M+C regulatory environment is one reason cited by health plans for their mass exodus from the program. In response, 37 states have passed laws accepting industry-based accreditation as satisfying all or part of state oversight requirements. Texas, however, has not passed such legislation and prepares to increase state oversight on HMO operations.

This content analysis study examined the current oversight models used by federal and state government regulators and compared these auditing tools to an industry-based accreditation survey. Results suggest that significant differences do exist among the current models ($\alpha = .05$) regarding the emphasis they place on the four oversight topics of finance, beneficiary protection and information, quality assessment and improvement, and plan management. By developing a M+C supplement to its current accreditation survey process, the NCQA could eliminate the differences in the models. This initiative would result in lower costs for both regulators and health plans. By law, the health plans would be required to pass along approximately \$400,000 dollars in additional benefits to over 361,000 Texans participating in the M+C program.

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A Comparison of the Audit and Accreditation Tools Used By
The Health Care Financing Administration, The Texas Department of Insurance, and The
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The Cost of Multi-Agency Oversight on Medicare+Choice Plans in Texas

There is little doubt that historians, when examining the last U.S. presidential election, will focus much of their attention on the post-election day courtroom battles. Unfortunately, the emphasis given to the month-long drama will likely overshadow the debate that raged over important social issues for the year and a half preceeding November 14, 2000. Once again, health care was on the minds of American voters. A January 2000 Dartmouth College/Associated Press poll identified it as the number one policy priority among both democrats and republicans likely to vote in the presidential primaries (Zarcone, 2000). At the same time, many Health Maintenance Organizations (HMOs) participating in the Medicare+Choice program (M+C) either reduced the level of benefits offered to enrollees or pulled out of the program entirely. The impact on seniors was substantial. On 1 January 2001, an estimated 711,000 elderly patients were forced to look for new Medicare HMO coverage or return to the fee-for-service (FFS) system due to the large exodus from the M+C program by health plans (Tokarski, 2000). In the last few weeks prior to the critical election day, politicians on all sides scrambled to portray themselves as supporters of the Medicare system. In October 2000, Congressional leaders in both the House and Senate agreed to raise payments for Medicare providers by \$28 billion over the next five years (Murray & McGinley, 2000).

The political attention to health care issues in general, and Medicare in particular, is no accident. Powerful consumer groups have made their concerns known. An American Association of Retired Persons (AARP) poll found that Medicare, long-term care, and patient

protection were three of the four most important election issues to its members. The fourth issue was Social Security. As a result, AARP mounted its largest ever nonpartisan voter-education initiative for this past presidential election (Zarcone, 2000). Thus, despite White House protests that the Medicare bill was far too generous to managed-care organizations, the political reality of an election year guaranteed a substantial increase in Medicare funding (Murray & McGinley, 2000).

Health plans attribute the decision to halt or limit their participation in the M+C program to three main reasons: inadequate payment by the federal government as a result of the Balanced Budget Act of 1997 (BBA); the high medical costs of caring for an elderly population; and the excessive and costly regulatory oversight of the M+C program. In an effort to respond to these complaints, the Health Care Financing Administration (HCFA) said it would streamline some administrative rules that health plans have faulted as burdensome and unnecessary. The agency reduced some HMO contracting requirements, loosened restrictions on marketing materials aimed at seniors and helped health plans work with employers seeking retiree medical coverage for their workers (Tokarski, 2000).

Because HMOs were the first plans to link health care delivery and financing systems on a pre-paid basis, the industry has been subject to a higher level of regulatory oversight for quality assurance activities than other forms of health insurance (Carneal, 1997). With the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), additional regulatory requirements became effective in January 2000 (General Accounting Office [GAO], 2000).

Indeed, the trend is for increased regulatory oversight of the HMO industry. In addition to HCFA requirements at the federal level, state governments and industry-based accrediting organizations continue to expand their scope of oversight involvement. The impact of this trend

on the cost of providing health care services is significant. The number of state laws mandating health benefits for plan enrollees is on the rise. According to the National Center for Policy Analysis, there were only five mandated health benefits on the books in the entire fifty states in 1968 compared to 1,391 at the end of 1999. A total of 63 mandated benefits are currently reflected in Texas state law alone. In a recent study by the Texas Department of Insurance (TDI), five of these mandated benefits resulted in a 17 percent increase in the premiums health plans charged (Texas Association of Business and Chambers of Commerce [TABCC], 2000).

This paper examines the various oversight models used by regulatory and industry-base agencies on the health care system. In particular, the regulatory tools used at the federal and state levels and how accreditation processes by industry-based organizations such as the National Committee on Quality Assurance (NCQA), which is encouraged by employer groups and other purchasers of health care services, compare with regulatory audits. It examines duplication among the oversight agencies and the cost of this redundancy to the health system. Finally, if beneficiary protection can be assured, can efficiencies to both the health plan and the government be realized by the delegation of some oversight responsibilities? At a time of rising Medicare costs, increasing regulatory requirements, and growing instability in many Medicare markets, it is pertinent to examine any and all areas of the Medicare program for possible cost savings.

Conditions Which Prompted the Study

In addition to the widespread pull out of HMOs from the Medicare market, several events impacting regulators, health plans, and beneficiaries loom on the horizon that could have serious implications to the future success of the M+C program. Specifically, major areas of concern are: HCFA's implementation of a revised M+C payment methodology; the threat of new managed

care requirements resulting from new federal and state legislative sessions; and the increase in M+C premiums and the subsequent reduction of some benefits to seniors.

Revised M+C Payment Methodology. Currently, the federal government pays M+C HMOs a monthly capitation payment for each Medicare member enrolled to its plan. HMOs with a Medicare risk contract are paid 95 percent of what the government's actuaries estimate to be the cost of medical services if the services had been obtained in traditional FFS Medicare. In exchange for this payment, the HMO is required to provide the full range of health care services covered under the federal Medicare program. The adjusted average per capita cost (AAPCC) is the basis of payment to HMOs and can vary widely by location (Zarabozo & LeMasurier, 1997)

Government analysts speculated that, with growing enrollment, health plans would necessarily enroll a substantially larger share of less healthy beneficiaries. The GAO, however, reported that the sickest beneficiaries tended to remain in FFS while the healthier seniors joined managed care plans. As FFS spending grew, so too did the payment to HMOs since their rates were tied to 95 percent of FFS costs (GAO, 1999).

In response to this scenario, the BBA established a new, risk-adjusted payment rate method for M+C plans. The Principal Inpatient Diagnostic Cost Group (PIP-DCG) is designed, per government reports, to use hospital inpatient data to match managed care payments to beneficiaries' expected health care costs. To summarize, HCFA would review inpatient utilization for the previous year and assign individuals who were diagnosed for a condition that normally required further medical costs to a PIP-DCG payment category. To determine which specific diagnoses to include, HCFA relied on the advice of a clinical panel. The panel recommended that diagnoses associated with about one-third of hospital admissions be excluded

because they (1) could be ambiguous, (2) were for conditions that were rarely the main cause for an inpatient stay, or (3) were not good predictors of future health care costs (GAO, 1999).

The potential impact of the PIP-DCG payment methodology on M+C plans is significant. Currently, plans must sign a M+C contract lasting at least one year. During the contract term, premiums and benefits offered to Medicare members can not change. Prior to entering into a new contract year, plans submit an adjusted community rate (ACR) document to HCFA. The ACR reflects a plan's premium that it would charge a commercial group for the same benefit package as Medicare. All of the plan's projected costs are reflected on the ACR as well as expected normal profit for a for-profit HMO. HCFA then compares the projected premium reflected on the ACR to the projected payments. The payment rate is considered appropriate if the ACR is higher than the projected payment. If the ACR reflects a lower premium, the plan is required to either return the surplus to HCFA or offer an enriched benefit package equal to the dollar amount of the surplus (Zarabozo & LeMasurier, 1997).

In short, a plan loses money if it underestimates its health care costs on the ACR. With the implementation of the PIP-DCG, forecasting of projected costs and revenues will become even more difficult. Responding to industry concerns, Congress delayed full implementation of the new payment methodology via the Balanced Budget Refinement Act (BBRA) of 1999. Instead, HCFA was instructed to phase-in the new payment methodology over the calendar years 2000 through 2004. On 1 January 2000, HCFA began applying the PIP-DCG to 10 percent of a health plan's enrolled Medicare population. Analysts project a 0.6 percent reduction in Medicare payments based on the first year of PIP-DCG usage (Department of Health and Human Services, Office of the Inspector General [DHHS OIG], 2000).

Threat of New Managed Care Legislation. Early government oversight of the Medicare program focused on ensuring fiscal integrity and beneficiary protection. As the federal government began to gain experience with capitation, it began to monitor more closely other aspects to include: the reasonableness of payment to plans, HMO incentives to health care providers, and denials of medically necessary services to plan enrollees (Abbey, 1997). As previously mentioned, health care is the top priority of the politically active senior population. As such, it is logical to expect some legislation impacting managed care plans early in the new legislative year. In fact, the new administration is aggressively seeking legislation on two key issues--prescription drugs for seniors and the patient bill of rights (McCaleb, 2000).

The 77th session of the Texas State Legislature, which convenes every other year, began January 2001. Texas has been very active in adopting managed care legislation. In 1997, it passed a comprehensive patient rights law that gave people the right to sue their managed care organization (Patton, 1999). During the 76th session in 1999, the legislature passed a total of 38 laws impacting a wide variety of health care issues. Appendix A summarizes the laws affecting HMOs and other health care insurers that were passed by the Texas State Legislature in 1999 (Texas House of Representatives, 1999). Currently, 152 bills on various health care topics have been filed initially by members of the Texas House and Senate in preparation for the 77th legislative year. Although this number does not reflect the final amount of legislation that will actually make it through the various committees in both houses, the upcoming legislative session will attempt to pass bills defining the term “medical necessity” as it relates to health plan coverage and regulating the pre-authorization process between physicians and health plans (Eiland, et al., 2000).

Increased M+C Premiums and Reduced Benefits. Nationwide, Medicare beneficiaries enrolled in a managed care plan are seeing an increase in premiums and a reduction in benefits. Research suggests that the biggest factor drawing Medicare beneficiaries to a M+C plan is the supplemental benefits, which are often offered at no additional cost. There is great concern, however, that such options will be less available in the future. As a result, Medicare beneficiaries with moderate incomes may lose the most affordable way of gaining supplemental coverage (Cassidy & Gold, 2000).

Fewer HMOs are offering a M+C plan with no additional premium. In 1999, 62 percent of the M+C markets had plans that offered no premium compared to only 42 percent in 2000. Premiums are also on the rise. Research shows that, on the average, M+C premiums have doubled from 1999 to 2000 nationwide (Cassidy & Gold, 2000).

While premiums are increasing, the availability of key benefits for Medicare members is on the decline. A GAO study in 1999 reported that the change in additional benefits from 1997 to 1999 was relatively small. Research suggests that the rate of the reduction in benefits is rapidly increasing however. Most notably, prescription drug coverage is included in only 68 percent of basic plans in 2000, compared to 73 percent in 1999. Coverage for preventive dental benefits is included in only 30 percent of basic plans in 2000, down from 40 percent in 1999. Chiropractic benefits, always relatively limited, are being offered in even fewer plans in 2000. Only 9 percent of basic plans offered chiropractic benefits in 2000, compared to 19 percent in 1999 (Cassidy & Gold, 2000)

In Texas, two HMOs either added monthly premiums or increased service charges for more than 100,000 Medicare members effective January 2001. In recent press releases, PacifiCare of Texas and Sierra Health Services blamed the charges on higher drug costs and inadequate federal

reimbursements. PacifiCare premium increases varied by area. For example, 62,000 seniors in North Texas now pay a \$19-a-month premium while the 26,000 Houston seniors covered by PacifiCare pay \$25. Sierra members have a choice between either paying a monthly premium or having a higher co-payment and a lower prescription drug benefit (The Wall Street Journal [WSJ], 2000).

Statement of the Problem

The BBA established the M+C program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. Currently, 20 percent of the approximately 40 million Medicare beneficiaries are enrolled in M+C plans (GAO, 2000). Research shows that, while Medicare costs to the federal government are increasing, beneficiaries in many parts of the country are losing their M+C option as health plans withdraw from the market. In areas where M+C plans remain, enrollees are facing higher out-of-pocket costs and receiving less benefits.

HMOs blame the trend on inadequate federal reimbursement and excessively high administrative costs due to overregulation. Indeed, the federal government itself will also incur more costs as it attempts to enforce an increasing amount of new statutory requirements. In addition to federal and state agencies, industry-based organizations accredit health plans and report the results to the public. Therefore, the management question is: if beneficiary protection can be maintained, can efficiencies and cost savings to the M+C program be realized by delegating oversight responsibilities to a qualified third party?

Literature Review

Few topics have received as much attention in public forums recently as the subjects of managed care and Medicare. Unfortunately, most of the attention has been negative in nature. Politicians and voter groups alike consistently call for Medicare reforms to correct perceived

deficiencies in benefit coverage and inefficiencies in administration. Managed care organizations in general, and HMOs in particular, have been the target of criticism from all fronts due to their perceived emphasis on cost containment. The demonization of the managed care industry has supplied politicians, journalists, and even comedians with plenty of opening line material. In a recent speech to members of the American Association of Health Plans, U.S. Senator John Breaux (D-LA) opened by saying the managed care industry owes the tire industry a debt of gratitude. Referring to the recent recall of millions of defective Bridgestone tires, Senator Breaux proclaimed that the tire industry has replaced HMOs as “public enemy number one” (J. Breaux, personal communication, September 12, 2000).

To address the issue of multi-level oversight of Medicare HMOs, the literature review begins with a brief discussion of the M+C program. Next, an overview of the various agencies, both public and private, that audit and accredit HMOs is provided. An overview of the Texas M+C market to also included and identifies HMO efforts to return to profitability as well as the major health plans operating in the state. Finally, key elements of managed care from the perspectives of the various oversight agencies are examined in order to establish a framework for comparison.

The Medicare+Choice Program. Medicare costs the federal government over \$200 billion annually. Estimates for the year 2001 suggest that Medicare expenses will comprise 12 percent of the federal budget. On average, Medicare fiscal intermediaries process about 900 million claims annually submitted by nearly one million hospitals, physicians, and other health care providers (GAO, 2000).

As of March 1999, approximately 20 percent of the roughly 40 million Medicare eligible beneficiaries were enrolled in 300 participating M+C HMOs. Most of these plans receive

payment on a prepaid basis called a capitation rate. Regardless of the amount or cost of the actual health care services provided, the health plan receives a fixed monthly amount to provide enrollees with the approved Medicare benefit package. Prior to the BBA, participating managed care organizations were reimbursed at 95 percent of the average FFS payment levels (GAO, 1999).

GAO auditors found that health care expenses for the M+C population actually increased despite being enrolled to a health care delivery system that emphasized cost effectiveness. The auditors discovered that payments to HMOs for their beneficiaries actually exceeded spending for similar beneficiaries in the traditional FFS system. The government attributed this excess spending to a payment system that did not adjust to a healthier-than-average population enrolled to Medicare HMOs (GAO, 1999). This “favorable selection”, per the DHHS OIG, resulted in a faulty actuarial assumption of the base year rate, and subsequently, government reimbursement to HMOs at a more than the 95 percent of FFS levels as reflected at Appendix B (DHHS OIG, 2000).

In a separate DHHS study, OIG auditors suggested that M+C plans earn an additional five percent return from short-term investments of Medicare’s prepayment funding. This occurs during the period that falls between the time the HMO receives the funds from HCFA and the time when these funds are disbursed to providers. The uniqueness of the prepaid payment system, DHHS contends, results in an additional \$100 million per year for HMOs (DHHS OIG, 2000).

Representatives of the managed care industry, however, dispute the government’s claim of excessive payments and point to the exodus of health plans from the M+C markets as evidence. In January 2000, 45 plans pulled out of the M+C market. As mentioned previously, additional

withdrawals for 2001 impacted 711,000 beneficiaries. Overall, the American Association of Health Plans (AAHP) reports that M+C enrollment is on the decline for the first time in a decade. M+C enrollment trends are reflected at Appendix C (AAHP, 2000). HMOs cite high administrative costs attributed to excessive regulatory oversight as one factor involved in plan withdrawals. According to GAO auditors, plans reported administrative costs equivalent to 1.3 percent of calendar year 2000 HMO payment rates on their ACR proposals (DHHS OIG, 2000).

The Health Care Financing Agency. HCFA, according to their website, is a federal agency responsible for administering Medicare, Medicaid, and the State Children's Health Insurance Program. Through these programs, HCFA provides health insurance for over 74 million Americans. In addition to providing health insurance, HCFA is responsible for the regulation of laboratory testing as well as the certification of health care facilities to include nursing homes, home health agencies, intermediate care facilities for the mentally retarded, and hospitals (HCFA, 2000).

Recent reports suggest that HCFA, under its present structure, has had difficulty in managing its vast array of duties. In recent testimony to the Senate Finance Committee, William J. Scanlon, the Director of Health Financing and Public Health Issues for the GAO, stated that key problems exist that impair HCFA's ability to effectively manage the Medicare program. Specifically, he noted that no one senior HCFA official is responsible for the daily management of Medicare. In addition, frequent changes in agency leadership make it difficult to develop and implement a consistent long-term vision. Finally, constraints on HCFA's ability to acquire appropriate resources and expertise limit HCFA's capacity to modernize Medicare operations. In response to these concerns, several draft legislative bills aimed at restructuring HCFA are currently in congressional subcommittees. Currently the two leading proposals to

reform Medicare are Senate Bill 1895 (the Breaux-Frist proposal) and the Clinton-backed Medicare Modernization Act of 2000. Appendix D summarizes HCFA's main oversight responsibilities in regards to Medicare and provides a comparison between the two major initiatives (GAO, 2000).

In 1998 and 1999, the GAO reported that HCFA was essentially overwhelmed in its efforts to handle the number and complexity of BBA requirements. In addition to HCFA's administrative structure, other problem areas such as the inability to attract and maintain qualified personnel and outdated information management systems have been identified that impede its effective management of the Medicare program. The impact of HCFA's inability to resolve these problem areas could be extremely critical in the near future. For example, the HCFA administrator recently testified that more than a third of the current HCFA workforce is eligible to retire within five years. In 1998, a DHHS OIG study reported that nearly all of the HCFA staff hired to work in the Medicare managed care area in the two previous years lacked HMO experience (GAO, 2000).

Studies suggest that the factors listed above have helped contribute to excess costs in the Medicare program. The waste is not limited to the M+C program. For example, a recent estimate by the DHHS OIG is that \$12.6 billion of fiscal year 1998 Medicare payments for FFS claims did not comply with Medicare rules (GAO, 2000). With the passage of HIPAA, the federal government's oversight into health insurance expanded into areas traditionally regulated by the state insurance departments. In states that pass laws comparable or more stringent than the federal standards, local insurance departments maintain primary regulatory authority. In states that fail to enact or enforce standards that conform to HIPAA, the DHHS (via HCFA) is required to enforce the standards (GAO, 2000).

State Oversight Agencies. Carneal (1997) outlined the oversight process at the state level.

Typically, regulatory supervision for HMO operations is shared by the state departments of insurance and health. Insurance regulators assume principal responsibility for the financial aspects of HMO operations. Health regulators focus on quality of care issues, utilization patterns, and the ability of participating providers to provide adequate care. HMOs obtain licensure by applying for a certificate of authority (COA) through the department of insurance. The licensure and recertification process provides state officials with a mechanism to ensure that the HMO is operating properly and is in compliance with all the applicable laws and regulations (Carneal, 1997).

The Texas Department of Insurance (TDI) is responsible for regulating the insurance industry, to include HMOs, in Texas. According to its stated mission, TDI works to protect consumers' interest by ensuring the availability of quality insurance products at reasonable prices and under reasonable terms. To accomplish this task, it enforces solvency standards and promotes competition in the industry while protecting consumers from fraud, misrepresentation and unfair practices. In addition, TDI personnel educate the public about insurance and acts as an advocate to protect consumers' interest (TDI, 2000).

According to its 1999 annual report, TDI identified two important trends in the health care industry in Texas. First, HMO enrollment growth continued to increase at a steady rate. In the years 1990 to 1999, total HMO enrollment increased almost 300 percent. At the end of 1999, almost 20 percent of the state's residents were in HMOs. Medicare beneficiaries, however, faced a decline in HMO options. Five M+C HMOs left the market in 2000 resulting in 31,000 Medicare beneficiaries who were forced to change plans or return to FFS (TDI, 1999).

The second trend identified in the TDI report was the continued streak of financial losses among Texas HMOs. Specifically, TDI cited 14 consecutive money-losing quarters for the HMO industry. In 1998, Texas HMOs lost \$333 million dollars and only 13 out of 50 HMOs reported a profit. Also during 1999, the state recorded its first HMO insolvency since 1991. In response, TDI established tougher financial guidelines for HMOs to include a risk-based capital requirement which mandated that HMOs set aside assets to support all of their liabilities when determining compliance with statutory solvency standards (TDI, 1999).

Other significant legislative mandates impacting Texas HMOs include the “clean claims” and “delegated network” laws. A “clean claim”, as defined by Texas House Bill 610, is a completed claim that the HMO has processed, paid, and/or disputed in accordance with established TDI guidelines within a 45 day timeframe. HMOs face fines of up to \$1,000 per day for each day a claim remains unpaid in violation of the statute. A “delegated network”, as defined by Texas Senate Bill 890, is an entity, other than an HMO, that arranges for or provides medical care on a prospective basis and performs for an HMO any function regulated by the HMO Act. The bill requires that any HMO using a delegated network monitor claims, utilization management, and credentialing functions to ensure regulatory requirements are met (Texas House of Representatives, 1999).

Industry-Based Accrediting Organizations. Managed care organizations seek accreditation for a variety of reasons. HMOs use accreditation to gain a competitive edge in their local markets. Many point to accreditation as verification that their quality improvement system works. Lastly, HMOs seek accreditation because state laws or a major health care purchaser requires an external quality review process. Accreditation provides a stamp of approval from an independent outside agency (AAHP, 1999).

The major accrediting bodies for managed care organizations are the Accreditation Association for Ambulatory Health Care (AAAHC), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee on Quality Assurance (NCQA), and the American Accreditation Healthcare Commission (known as the URAC). Between 1996 and 1999, the total number of organizations accredited by these agencies has increased substantially. Appendix E outlines the number and types of healthcare organizations accredited by these agencies (AAHP, 1999).

There is a trend for states to recognize HMO accreditation by an approved accrediting body as satisfying some or all of state requirements for managed care licensure. Currently, 37 states and the District of Columbia have enacted legislation to recognize private accreditation or provide “deeming” status. In these states, health plans are “deemed” to be in compliance with relevant state mandates if they achieve and maintain accreditation. Texas, despite being very active in legislating mandates for the managed care industry, does not have a deeming option (AAHP, 1999).

Research suggests that health plans that participate in the accreditation process achieve better clinical performance than their non-accredited counterparts. In the State of Managed Care Report for 2000, published by the NCQA, accredited health plans consistently scored higher on both clinical and customer satisfaction measures (see Appendix F).

The Texas Medicare+Choice Market. Value-Line industry analysts report that most HMOs have implemented several cost-containment initiatives that have resulted in a return to profitability. Specifically, actions such as adjusting benefit plans, sharing risks with providers, exiting unprofitable markets, and adding premiums for supplemental benefits have helped control most expenses. Pharmacy costs are the fastest rising health care expense and the industry

is responding by contracting with pharmacy benefit management companies, purchasing drugs wholesale, establishing drug utilization review programs, and implementing a tiered drug benefit program. In the market, both providers and HMOs have seen a period of consolidation. Providers and hospitals are merging to establish more negotiating power with HMOs. Managed care plans are merging in an effort to increase market share. Analysts expect the rate of consolidation to slow in the months ahead. One particular obstacle to continued mergers was the IRS ruling that restricted joint-venture efforts between for-profit and not-for-profit health care organizations (Value-Line, 1999).

PacifiCare Health Systems, Inc. (PHS) is a investor-owned, HMO serving the states of Arizona, California, Colorado, Kentucky, Nevada, Ohio, Oklahoma, Oregon, Texas, Washington, and the territory of Guam. It is one of the nation's largest managed care providers. In business for over 22 years, primary operations include commercial and M+C managed care products for four million members. Of that number, a little over one million are enrolled in their M+C plan called Secure Horizons. Other specialty products and operations include behavioral health services, life and health insurance, dental and vision services, pharmacy benefit management and M+C management services (PHS, 2000). PacifiCare's share of the national M+C market is considerable. After last summer's announcement of planned HMO withdrawals, Robert W. O'Leary (then PHS President and Chief Executive Officer) noted that, effective 1 January 2001, one out of every six M+C beneficiaries will be a Secure Horizon's member (R. O'Leary, personal communication, August 10, 2000).

PacifiCare of Texas (PCTX), a subsidiary of PHS, was established in 1986. PCTX operates a group and individual provider association (IPA) model network in the greater San Antonio, Houston, Dallas and Fort Worth, and Galveston service areas. As in markets nationwide, three

Texas HMOs were acquired by larger competitors in 1999. Aetna, PacifiCare, and Humana increased their share of the market by acquiring Prudential, Harris Health, and Memorial Sisters of Charity respectively. As of August 2000, nine M+C plans operate in Texas with a total enrollment of 361,699 Medicare beneficiaries. M+C penetration in Texas is 16.3 percent and is roughly the same as the national average of 16.4% (AAHP, 2000). Table 1 provides an overview of the current M+C market in Texas (PHS, 2000).

Table 1

M+C Market Share in Texas (August 2000).

Plan	Current M+C Membership	Percent of Total Texas M+C Market
Aetna	136,075	37.62%
PCTX	110,900	30.87%
Humana	73,542	20.33%
TRICARE	14,061	3.89%
Kaiser	6,610	1.83%
Seton Health Plan	6,248	1.73%
HMO Texas	5,293	1.46%
MethodistCare	5,271	1.46%
CIGNA	2,524	0.70%

Source: PacifiCare Health Systems, 2000

The cost of multi-agency oversight for these HMOs is considerable. According to interviews with PCTX managers, the organization paid over \$130,000 in 1999 in fees to oversight agencies for accreditation and auditing. NCQA accreditation cost PCTX \$80,000 (A. Ramon, personal communication, October 5, 2000). Similarly, the fee for a TDI quality audit is

\$50,000 and is conducted every three years (H. Mace, personal communication, October 5, 2000). When applying these figures to the total Texas M+C market, almost \$1.2M in fees are paid to oversight agencies. Although, HCFA does not charge a fee for its audits, HMOs still accumulate some costs in preparing for and hosting HCFA auditors and in satisfying HCFA reporting requirements (M. Harlan, personal communication, October 5, 2000).

Key Elements of Managed Care Oversight. Appendix G provides a comparison of the various oversight agencies. Gonia (1997) asserts that three external forces shape the operations of an HMO. These forces comprise the major regulators and purchasers of health care services: federal and state governments, employer-groups, and voluntary accrediting organizations (Gonia, 1997). Griffith (1995) labels these forces “customer partners”. The following section provides a brief discussion of the key oversight elements employed at the federal and state levels. Employer-group interests are represented by examining the NCQA’s accreditation requirements.

In 1999, HCFA introduced the Quality Improvement System for Managed Care (QISMC). The system, aimed at Medicare and Medicaid managed care products, requires managed care organizations to implement improvement programs, which focus on such areas as developing quality improvement studies and interventions, improving the access to care and the availability of care, and establishing more stringent grievance and appeals processes. QISMC regulations include new requirements that focus on quality improvement activities that are performed by M+C organizations. These regulations fall into four domains of standards and became effective on January 1, 2000 (AAHP, 1999).

Carneal (1997) identified the key elements of most state insurance departments in relation to HMO oversight. Most state insurance departments employ an oversight model developed in

cooperation with the National Association of Insurance Commissioners (NAIC). NAIC is a voluntary organization of the chief insurance regulatory officials of the 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the Virgin Islands. NAIC's stated mission is to assist state insurance regulators in protecting consumers and helping to maintain the financial stability of the insurance industry. NAIC promulgates model laws, regulations, and guidelines, intended to provide a uniform basis from which all states can deal with regulatory issues (GAO, 1998).

In 1989, responding to demands of health care purchasers for a method to compare the various managed care plans, the NCQA developed a "report card" which standardized key quality and financial indicators on participating plans. The Health Plan Employer Data and Information Set (HEDIS) presently contains 71 measures of managed care organizational performance which are divided into eight categories (Meisenheimer, 1997). The report card system has been a popular tool for human resource managers. The NCQA estimates that over half of corporations with 5,000 or more employees use this data in their decisions about health plan purchases (Sultz & Young, 1999).

On the surface, elements of the three oversight models can be grouped into three main categories: financial (to include health care costs, plan solvency, and provider reimbursement); beneficiary protection (to include enrollee information and grievance procedures); and clinical quality (to include quality improvement and assessment efforts as well as the availability of medical services). Appendix H represents this comparison of the three models in graphic form.

In summary, the literature suggests that the M+C program continues to cost the federal government more than anticipated and, at the same time, beneficiaries are faced with an instable market and less overall benefits. HCFA's oversight of the M+C program has been hampered by

limitations in its human resources and information management departments. In addition, government audits show that HCFA will be incapable of managing the additional oversight burdens required by HIPAA. State insurance departments, traditionally focusing on solvency and consumer grievances issues, have branched out into regulating other aspects of managed care due to increased mandates by state legislatures. The number of health care organizations that are accredited from industry-based organizations is increasing due to the demands by major health care purchasers and the benefits of deeming legislation in some states. Federal, state, and industry-based oversight agencies, with few exceptions, structure their oversight processes to address the critical managed care elements of financial solvency and payments, beneficiary protection and information, and clinical quality assessment and improvement.

Purpose

Based upon the literature review, to include the initial observation that the three oversight agencies attempt to measure compliance in similar areas, the objective of this project is to determine if NCQA accreditation satisfies HCFA and TDI requirements. If so, what are the cost savings, if any, for a for-profit Medicare HMO if HCFA and TDI implemented “deeming” authorization? If not, how can the NCQA accreditation process be modified to satisfy federal and state regulatory requirements and eliminate multi-agency oversight?

Methods and Procedures

A content analysis study was conducted using participant-observed data to determine if the NCQA accreditation standards satisfy HCFA and TDI oversight requirements. This section discusses the content analysis research method, outlines the design developed for the study, and provides the statistical tools used in data analysis.

Content Analysis

Content analysis is a qualitative research method, using observational data, designed to aid the researcher in obtaining “objective, and quantitative descriptions” of the content of various forms of communication (Marshall & Rossman, 1989, p. 98). By systematically establishing criteria, categorizing and coding the observed data, content analysis is a method of producing countable results for any form of communication (written materials, music, speeches, etc.). Goals of content analysis studies include producing descriptive information, cross-validating research findings, or testing hypotheses. When content analysis is used to explore relationships, chi-square analyses is often used (Marshall & Rossman, 1989).

No research design is perfect (Patton, 1990, p. 162). As in any research method, content analysis contains strengths and weaknesses that the researcher must be aware of when conducting a study. One strength of content analysis is that data are easy to manipulate and categorize. This allows for efficient data management and facilitates immediate follow-up and review for clarification and omissions. As previously mentioned, it is a method that easily produces quantifiable results for further statistical analysis. Weaknesses include the possibility that data may be misinterpreted in the coding process due to cultural differences or participant bias. Finally, as in most research designs, content analysis depends heavily on the accuracy of the initial research question (Marshall & Rossman, 1989).

Research reveals some common errors that are often found in content analysis studies. First, students typically select content that is easily available but does not represent an unbiased sample of all content related to the research objective. Second, the researcher fails to determine the reliability of his content-analysis procedures. Finally, the researcher uses classification categories that are not sufficiently specific and comprehensive (Marshall & Rossman, 1989).

Research Design

Data Collection. The author reviewed the latest published HCFA, TDI, and NCQA oversight standards and developed a database to store and categorize each standard. Sources used for this study were HCFA's "M+C Contractor Performance Monitoring System" (2000), TDI's "Quality Assurance Audit" (2000), and the NCQA's "Surveyor Guidelines for the Accreditation of MCOs" (2000). After reviewing the federal and state regulatory audit tools, each standard was subsequently categorized by two variables: 1) major oversight element and 2) method of evaluation. Variable definitions and codes are outlined at Appendix I. The major oversight element variable was defined as the principle area of concern associated with the standard as determined by the stated purpose and description of each. Every inspection item was coded using a number ranging from one to four (ordinal data) corresponding to the appropriate classification. Of note, the categories for major oversight element are the same as identified earlier with one addition. The category "plan management" was added to cover the items that dealt with a plan's organizational structure, oversight committees, and reporting requirements. The method of evaluation variable was defined as the method used in assessing compliance of the standard as described in the published sources. Evaluation methods were categorized in rank order and assigned a number ranking from one to three (ordinal data) corresponding to the appropriate classification. An evaluation method classification of three was determined to be the most stringent form of inspection. Subsequently, an evaluation method classification of one was considered the least stringent method of inspection. Finally, the NCQA model was reviewed and each item categorized using the codes and definitions developed from the regulatory standards.

Reliability and Validity. The test-retest method was employed to ensure reliability in the coding process. The author categorized each standard twice using the criteria for major

oversight element defined above. A 30-day time-period elapsed between each session to reduce respondent bias. Due to the detailed descriptions provided for each item, the results of each coding session were identical. Reliability was not tested for the method of evaluation variable. Since the published sources clearly assigned an evaluation method for each standard, coding for this variable would not be affected by the judgment of the researcher.

Content validity refers to the extent a measuring instrument provides adequate coverage of the topic under study (Cooper & Schindler, 1998). For this project, all HCFA, TDI and NCQA inspection standards were reviewed and categorized in two phases. First, categories for the major oversight element variable were developed by grouping similar standards from the inspection models used by federal and state regulatory agencies based on the published description and purpose. Next, NCQA requirements were coded based upon the criteria developed from the regulatory models. It is important to note that, while the specific definitions assigned to the variables and the actual classification of inspection items could vary by researcher, using the HCFA and TDI models as guidelines for developing the variables ensures that a consistent classification methodology is used for comparison with NQCA.

Population versus Sample Statistics. It is important to briefly discuss the rationale in using random samples from the three oversight models instead of comparing the entire population of inspection items. Typically, sample statistics are used to make inferences about the characteristics of a population when it is impractical to examine every element of that population. Indeed, because sampling is generally less expensive, faster, and just as accurate as population studies, it is the rule rather than the exception in most research designs (D. Sanders, 1995).

Since this project is narrow in focus and concentrates strictly on three oversight agencies that regulate M+C HMOs operating in Texas, all inspection items could have easily been compared. As discussed in the literature review, however, many industry-based organizations have developed accreditation programs. In addition, 12 state insurance agencies are currently active in performing oversight responsibilities using audits designed to ensure that local mandates are satisfied. By designing this study using sample statistics, the researcher hopes to develop a practical model to facilitate future comparisons on a multi-agency and multi-state level.

Statistical Analysis

Two nonparametric statistical tests were accomplished to determine if significant differences exist between the three oversight tools. The chi-square goodness of fit test was used to compare the distribution of inspection items by major oversight element codes. Next, the Wilcoxon signed rank test was accomplished to check for differences in the methods of evaluation used within each major oversight element. Alpha for both tests was set at .05.

Descriptive Statistics. Appendix I also contains detailed descriptive statistics for each oversight model. Of the 262 individual inspection items in the HCFA model, the majority (45.42 percent) were devoted to beneficiary protection and information. Over half of the 403 total inspection items for the TDI audit tool concentrated on overall plan management (52.36 percent). Likewise, 51.48 percent of the 439 total inspection items for NCQA focused on plan management issues. Financial issues were by far the least inspected area in each model. HCFA assigned 6.49 percent of its model to financial issues. TDI and NCQA, on the other hand, devoted less than one percent of their auditing tool to the area of finance (see Table 2).

For the method of evaluation variable, the codes represent a degree of evaluation ranging from least stringent (method of evaluation code “1”) to most stringent (code “3”). In the HCFA model, only 19 percent of the inspection items are evaluated solely based on interviews and review of internal organizational documents compared to 52 percent and 41 percent of the TDI and NCQA models respectively. On the other hand, almost 60 percent of the NCQA accreditation survey items required the most stringent evaluation methodology to be used for grading compliance (see Table 3).

Table 2

Distribution of Major Oversight Element Variable by Model (Percentage of Total Items).

Variable	Model		
	HCFA	TDI	NCQA
Financial	6.49%	0.99%	0.46%
Beneficiary Protection	45.42%	30.52%	26.65%
Quality Assessment	20.99%	16.13%	21.41%
Plan Management	27.10%	52.36%	51.48%

Table 3

Distribution of Method of Evaluation Variable by Model (Percentage of Total Items).

Variable	Model		
	HCFA	TDI	NCQA
Method 1	19%	52%	41%
Method 2	43%	23%	0%
Method 3	38%	25%	59%

Comparison by Major Oversight Element. Using the random number generator application available in the Microsoft Excel software package, a sample of 100 inspection items was randomly selected from each oversight tool by database record number. Because each model contained a different number of inspection items, a separate random number table was created for each model to ensure that every item had an equal chance to be selected. Two chi-square goodness of fit tests were accomplished comparing first the HCFA and NCQA samples and, subsequently, TDI and NCQA data. Table 4 lists the descriptive statistics for the three samples. For each test, the frequencies of each major oversight element code were tabulated. The totals for the regulatory sample were designated as the expected frequencies (E). The NCQA sample was labeled the observed frequencies (O). The test ratio (TR) was computed for each test by squaring the difference between O and E and dividing that number by E. The critical value (CV) for each test was identified from the chi-square distribution table ($\alpha = .05$; three degrees of freedom [df]) as 7.81 (Sanders, 1990, p. A-16).

Table 4
Descriptive Statistics for Chi-Square Samples (Major Oversight Element Variable).

Model	N	Mean	Standard Deviation	Variance	Minimum	Maximum
HCFA	100	2.78	.97	.94	1	4
TDI	100	3.18	.95	.9	1	4
NCQA	100	3.13	.88	.77	2	4

Comparison by Method of Evaluation. Next, the Wilcoxon signed rank test was accomplished on the sample items obtained above for comparison of the methods of evaluation used by each oversight model. Table 5 provides the descriptive statistics for the method of evaluation variable. Similar to the first test, the method of evaluation variables for the regulatory

inspection items were designated as the original score and paired with an NCQA inspection item from the same major oversight element. The NCQA sample was labeled as the new score and this value was subtracted from the original. Differences between the pairs of data were assigned a ranked order irrespective of their positive or negative sign. Subsequently, the sums of both the positive and negative ranks were computed to obtain the T-statistic used to compare the critical values for this test. A total of eight separate tests were conducted. First, all 100 sample items from the HCFA and TDI models were paired separately against the NCQA data. Subsequently, samples items were sorted and compared within three of the four major oversight elements. The financial oversight element could not be tested due to the small sample size (less than five pairs). Appendix K provides the worksheets used to compute the eight T-statistics. Critical values for each test are listed at Table 6 (Sanders, 1990, p. A-17).

Table 5

Descriptive Statistics for Wilcoxon Signed Rank Test Samples (Method of Evaluation Variable).

Model	N	Mean	Standard Deviation	Variance	Minimum	Maximum
HCFA	100	2.23	.723	.522	1	3
TDI	100	1.68	.777	.604	1	3
NCQA	100	2.32	.952	.907	1	3

Table 6

Number of Pairs and Critical Values for Wilcoxon Signed Rank Tests.

Test	Comparison	# of Pairs (N)	Critical Value (.05)
1	HCFA & NCQA (All samples)	72	907
2	TDI & NCQA (All samples)	71	907
3	HCFA & NCQA (Oversight element 2)	29	126
4	HCFA & NCQA (Oversight Element 3)	12	13
5	HCFA & NCQA (Oversight Element 4)	15	25
6	TDI & NCQA (Oversight element 2)	30	137
7	TDI & NCQA (Oversight element 3)	7	2
8	TDI & NCQA (Oversight element 4)	27	107

Hypotheses

Table 7 outlines the hypotheses used for each statistical test. For the chi-square goodness of fit test, the null hypothesis (Ho) is rejected and the alternate hypothesis (Ha) is accepted if the TR is greater than 7.81. If the TR is less than 7.81, Ho is accepted. For the Wilcoxon signed rank test, Ho is rejected and Ha is accepted if T is greater than the appropriate CV based on the final number of pairs evaluated (n). Ho is accepted for any result where T is less than CV.

If the null hypotheses for both tests are accepted, the study would suggest that the NCQA model is similar in scope and method of evaluation to the audit tools used by both federal and state regulatory agencies. This result would give credence to the argument that multi-agency oversight, using the current auditing tools, is duplicative in nature and results in unnecessary costs to the health care system in Texas. If the results of either statistical test rejects a null

hypotheses and accepts the alternate, the study would suggest that significant differences exist among the oversight models.

Table 7

Declaration of Null and Alternate Hypotheses.

Test	Decision criteria	Null Hypothesis (Ho)	Alternate Hypothesis (Ha)
Chi-Square Goodness of Fit	Accept Ha if $TR > 7.81$	The population distribution for major oversight element is uniform between the regulatory agency and NCQA models. As such, there is no difference in the areas evaluated in each model or in the proportion of audit devoted to each area.	The population distribution for major oversight element is not uniform between the regulatory agency and NCQA models. Therefore, there are differences in either the areas evaluated in each model and/or the proportion of audit devoted to each area.
Wilcoxon Signed Rank Test	Accept Ha if $T > CV$	The methods of evaluation used to ensure compliance is the same among each oversight element for the regulatory agency and NCQA. There is no difference in how the standards are inspected.	The methods of evaluation used to ensure compliance is different among each oversight element for the regulatory agency and NCQA. There is a difference in how the standards are inspected.

Power Analysis. Power is the probability that a statistical test will detect a false hypothesis (Thorne & Slane, 1997, p. 203). Two types of errors are possible when conducting hypothesis testing. A Type I error occurs when a true null hypothesis is rejected. A Type II error occurs when a researcher fails to reject a false null hypothesis. Type I errors occur when the zones of rejection, established by the level of significance (or alpha), are too large to detect differences with confidence. Several factors contribute to committing a Type II error and include: 1) the true value of the parameter; 2) the alpha level selected; 3) whether a one-tailed or two-tailed test is used; 4) the standard deviation of the sample; and 5) the sample size (Cooper & Schindler, 1998, p. 473).

It is important to examine the potential costs of each error type in designing a research study. Specifically, when a greater emphasis is placed on reducing the probability of a Type I error (ie. a smaller the level of significance [or alpha]), the power of the test to reject a false null hypothesis is reduced. Parametric tests are more powerful than their nonparametric counterparts but operate under the critical assumption that the data are normally distributive. In cases where sample data are not normally distributive, nonparametric tests may be more powerful (Christensen & Stoup, 1991). If the researcher can predict the direction of the difference, a one-tail test (because it considers only one end of the distribution) is a more powerful tool than a two-tailed test. If the prediction proves wrong, however, a one-tail test becomes absolutely useless (Thorne & Slane, 1997). Croxton, Cowden, and Klein (1967, p. 549) narrow the discussion of power and the trade-off between Type I and Type II errors down to the pertinent question at hand: which error is more important?

Table 8 compares the two types of errors and their potential impact on the results of this study. In a worse case scenario, a Type I error could result in the continuation of the current

regulatory environment (ie. the status quo). A Type II error, on the other hand, could give a false assumption that the oversight models are similar and initiate the movement to enact deeming legislation in Texas. Lawmakers could, unwittingly, pass legislation resulting in lower beneficiary protection for seniors. In the researcher's opinion, the potential impact of a Type II error is more serious for the M+C program. As a result, several aspects of this study were designed to reduce Type II errors as much as possible. First, nonparametric tests were chosen because the distribution of the sample data for both variables were not uniform (please refer back to Figures 1 and 2). Next, large sample sizes were drawn for analysis to better reflect the parameters of the population as a whole. Specifically, the 100 samples for each model comprise approximately 38 percent of the HCFA model, 25 percent of all TDI items, and 22.8 percent of NCQA standards. Third, since the standard deviations for each sample were small, two-tailed tests were accomplished to eliminate any assumptions regarding the direction of possible differences. Finally, alpha was established at .05 (versus .01) to determine statistical significance. In other words, using the sample data selected, the tests should correctly accept a true null hypothesis 95 times out of 100.

Table 8

Potential Impact of Type I and Type II Errors for This Study.

Error	Description	Potential Impact
Type I	Researcher rejects a true Ho	Deeming legislation would not be introduced in Texas because of concerns over differences in the oversight models. Plans would continue to undergo multi-agency oversight.
Type II	Researcher fails to reject a false Ho	Statistical differences exist between the oversight models but are not detected. Deeming legislation could be introduced and passed based on the assumption that the oversight models were similar. Potential differences could impact quality and beneficiary protection issues.

Results

Major Oversight Element

Tables 9 and 10 are the worksheets used to compute the TR for the two chi-square tests. Table 11 reflects the results of the two chi-square goodness of fit tests performed. Significant differences were found in the distribution of major oversight elements in each comparison. The TR for each test was well above the minimum critical value required for significance ($\alpha = .05$, 3 df) and surpassed the critical value required for significance at $\alpha = .01$ as well. The results suggest that differences exist between the oversight models in regards to the areas evaluated and/or the proportion of oversight devoted to each area.

Table 9

TR Worksheet (NCQA and HCFA models).

Major Oversight Element Category	NCQA (Observed)	HCFA (Expected)	Computations		
			(O-E)	(O-E) ²	(O-E) ² /E
1	0	5	-5	25	5
2	33	45	-12	144	3.2
3	21	17	4	16	.941
4	46	33	13	169	5.12
Totals	100	100	0		14.26
TR=					14.26

Table 10

TR Worksheet (NCQA and TDI models).

Major Oversight Element Category	NCQA (Observed)	TDI (Expected)	Computations		
			(O-E)	(O-E) ²	(O-E) ² /E
1	0	1	-1	1	1
2	33	34	-1	1	1
3	21	11	10	100	9.09
4	46	54	-8	64	1.185
Totals	100	100	0		12.275
TR=					12.275

Table 11

Results of Chi-Square Goodness of Fit Tests.

Test	n	Degrees of Freedom (df)	True Ratio (TR)	Critical Value (.05)	Critical Value (.01)
1. HCFA and NCQA	100	3	14.26*	7.81	11.34
2. TDI and NCQA	100	3	12.275*	7.81	11.34

Note: * denotes significance ($\alpha = .01$)

Method of Evaluation

Table 12 reflects the results of the eight Wilcoxon signed rank tests performed. No significant differences were found when comparing the method of evaluation used for all 100 sample pairs. In each case, the T statistic is well below the critical value required for significance ($\alpha = .05$) and suggests a strong similarity among the oversight models in regards to how the items are evaluated.

A significant difference was found in only one of the six tests performed comparing the method of evaluation used within each major oversight element. As a result, the tests suggest that the models employ similar methods of evaluating like items.

Table 12

Results of Wilcoxon Signed Rank Tests.

Test	Comparison	# of Pairs (N)	T	Critical Value (.05)
1	HCFA & NCQA (All samples)	72	559	907
2	TDI & NCQA (All samples)	71	169	907
3	HCFA & NCQA (Oversight element 2)	29	71	126
4	HCFA & NCQA (Oversight Element 3)	12	13*	13
5	HCFA & NCQA (Oversight Element 4)	15	15	25
6	TDI & NCQA (Oversight element 2)	30	5	137
7	TDI & NCQA (Oversight element 3)	7	0	2
8	TDI & NCQA (Oversight element 4)	27	15	107

Note: * denotes significance (alpha = .05)

In summary, based upon these results and the decision criteria, the null hypothesis is accepted. The results suggest that differences do exist among the oversight models at a statistically significant level. Specifically, the models differ in regards to the proportion of each tool devoted to a subject area (alpha = .01). The results also suggest that the oversight tools are similar in how items are evaluated. There is no significant difference in the method of evaluation used when comparing the entire 100 sample items. A statistically significant difference was identified in only one of the six tests performed comparing the method of evaluation used within each major oversight element (alpha = .05). Although the null hypothesis is accepted, a closer examination reveals that modifications could easily be made to the NCQA model to eliminate these differences.

Discussion

This section further examines the results of the statistical analysis and recommends ways in which the NCQA accreditation process could be modified to eliminate the differences found in comparisons with both the HCFA and TDI oversight models. Finally, the section concludes with a discussion of the potential impact to the M+C program resulting from these modifications.

HCFA and NCQA

At only 263 specific standards, HCFA's "M+C Contractor Performance Monitoring System" is the smallest of the oversight models. Consistent with HCFA's concern that plans strive to meet the needs of its seniors, almost half of the items (45.42 percent) focus on beneficiary protection and information. Special emphasis is paid to the published materials that are provided to Medicare eligibles to ensure that plans communicate information on benefits, providers, and appeals honestly and effectively. As such, over 40 percent of all HCFA inspection items are evaluated by reviewing marketing and enrollment materials, explanation of benefits, and other direct communication to plan members. In addition, approximately 6.5 percent of the monitoring guide is directed at financial elements of the HMO's operation. These items are aimed more at reducing Medicare expenditures and eliminating fraud. Thus, financial elements in the HCFA guide focus on accurate claims processing, reimbursement and eligibility determinations, and incentives to network providers.

The NCQA's "Surveyor Guidelines for the Accreditation of MCOs", contains 439 specific standards and is the largest of the three models examined. Developed primarily to meet the needs of business and employer groups, NCQA's emphasis is focused more on efficient plan management (51.48 percent). The accreditation process devotes a roughly equal share to quality and beneficiary protection issues (21 percent and 27 percent respectively) and little attention to

financial matters (less than .05 percent). With a mean method of evaluation of 2.32, NCQA appears to be relatively equal with HCFA on how items are inspected. Overall, more items are evaluated strictly via interviews and review of internal organizational documents with NCQA than in the HCFA model (41 percent to 19 percent respectively). Even still, this difference is not statistically significant. The Wilcoxon signed rank tests identified a statistically significant difference in the method of evaluation for the quality assessment and improvement element (element “3”). A closer examination reveals that, with a mean of 2.29, the NCQA quality items for this element were evaluated more stringently than HCFA’s (mean = 1.88). As such, no adjustments are needed in regards to how NCQA evaluates its standards.

TDI and NCQA

With 403 inspection items, TDI’s “Quality Assurance Audit” is similar in size and scope to NCQA. As such, the analysis produced a smaller, although still statistically significant, difference than did the HCFA/NCQA tests. Together, plan management and beneficiary protection issues comprise almost 83 percent of the TDI model. Contrary to its name however, quality assessment and improvement items comprise only 16 percent of the total TDI audit and is the least percentage of the three models for this area. With a mean of only 1.68, TDI also appears to be the least stringent when it comes to the methods of evaluation used in its model. Over half of the inspection items are evaluated using interviews and review of internal documents alone (method “1”).

Approximately one percent of the audit is devoted to financial issues. This is not a surprise considering that TDI has separate insurance evaluators who conduct financial audits on all types of insurance products. Table 13 is a revised TR worksheet for TDI and NCQA without the

finance element. The chi-square calculation reveals a statistically significant difference ($\alpha = .01$; 2 df) between the models even after discounting for the finance variable.

Table 13

Revised TR Worksheet Without Finance Element (NCQA and TDI models).

Major Oversight Element Category	NCQA (Observed)	TDI (Expected)	Computations		
			(O-E)	(O-E) ²	(O-E) ² /E
2	33	34	-1	1	1
3	21	11	10	100	9.09
	46	54	-8	64	1.185
4					11.275
Totals				TR=	11.275
				CV(.01)(2df)	9.21

The NCQA devotes more of its accreditation process to quality and plan management than TDI. On the other hand, it trails the insurance department on items focusing on beneficiary protection issues. As in the HCFA comparison, no adjustments are required for the method of evaluation variable since the NCQA employs a more stringent method of inspection than required in the TDI auditors manual.

Recommendation

Since the NCQA evaluates many types of plans, it must satisfy the needs of many stakeholders. To accomplish this, current NCQA standards could be supplemented with additional modules that would be used to augment the core accreditation process as the market requires. In short, the NCQA could build a M+C section that simply incorporates the additional HCFA requirements for financial management and beneficiary protection into the accreditation

survey for M+C plans. This section could be optional for plans since some HMOs operate strictly in the commercial market. These plans could however, choose to be evaluated with the supplemental standards in order to satisfy the requirements of state regulators such as TDI. Appendix L lists the 77 HCFA items that could be incorporated into the NCQA surveys. It is important to note that the inspection standards reflected in the appendix are not duplications of any current NCQA accreditation item. In fact, 17 deal with the unique financial requirements of the Medicare program and concentrate on reducing overpayments and fraud. The remaining 60 standards target HCFA's efforts to ensure beneficiary protection and information for all eligible seniors. As such, the items place heavy emphasis on enrollment and disenrollment procedures, marketing materials, and access.

Table 14 provides a comparison of the distribution of items by major oversight element for each of the current models as well as the proposed NCQA and M+C combination. The additional emphasis on financial and beneficiary protection increases the percentage of the accreditation process that is devoted to these areas.

Table 14

Comparison of Distribution of Major Oversight Element Variable for Current and Proposed Models (Percentage of Total Items).

Variable	Model			
	HCFA	TDI	NCQA	NCQA/M+C Supplement
Financial	6.49%	0.99%	0.46%	3.68%
Beneficiary Protection	45.42%	30.52%	26.65%	34.30%
Quality Assessment	20.99%	16.13%	21.41%	18.22%
Plan Management	27.10%	52.36%	51.48%	43.80%

To evaluate whether the additional standards would eliminate the statistical differences found in the models, a new random sample of 100 inspection items were selected from the modified NCQA survey with the M+C Supplement. Appendix M provides a listing of the new sample inspection items. Table 15 compares the descriptive statistics for the new sample with those collected earlier. Note that the new mean of 2.93 reflects a reduction in total emphasis in plan management and an increase in the proportion of the NCQA survey assigned to financial and beneficiary protection items. As in the earlier analysis, the chi-square goodness of fit tests were accomplished and a new TR computed to compare the new model with both HCFA and TDI audit tools (Tables 16 and 17 respectively).

Table 15

Descriptive Statistics for Chi-Square Samples (Major Oversight Element Variable).

Model	N	Mean	Standard Deviation	Variance	Minimum	Maximum
HCFA	100	2.78	.97	.94	1	4
TDI	100	3.18	.95	.9	1	4
NCQA	100	3.13	.88	.77	2	4
NCQA/M+C Supp	100	2.93	.998	.995	1	4

Table 16

TR Worksheet (Proposed NCQA/M+C Supplement and HCFA models).

Major Oversight Element Category	NCQA w/ M+C Supp (Observed)	HCFA (Expected)	Computations		
			(O-E)	(O-E) ²	(O-E) ² /E
1	5	5	0	0	0
2	38	45	-8	64	1.42
3	16	17	-1	1	.06
4	41	33	8	64	1.94
Totals	100	100	0		3.42
TR=					3.42

Table 17

TR Worksheet (Proposed NCQA/M+C Supplement and TDI models).

Major Oversight Element Category	NCQA w/ M+C Supp (Observed)	TDI (Expected)	Computations		
			(O-E)	(O-E) ²	(O-E) ² /E
1	5	1	4	16	16
2	38	34	4	16	.47
3	16	11	5	25	2.27
4	41	54	-13	169	3.13
Totals	100	100	0		21.87
TR= 21.87					

As expected, the significant difference between HCFA and NCQA models is eliminated when the M+C supplement is added to the accreditation survey. It is interesting to note that the differences between TDI and NCQA/M+C are greater than the earlier tests due to the increased emphasis on financial issues. However, unlike the previous chi-square analysis, Table 18 shows that the differences become insignificant when discounting for the financial element ($\alpha = .05$; 2 df).

Table 18

TR Worksheet (Proposed NCQA/M+C Supplement and TDI models).

Major Oversight Element Category	NCQA w/ M+C Supp (Observed)	TDI (Expected)	(O-E)	Computations (O-E) ²	(O-E) ² /E
2	38	34	4	16	.47
3	16	11	5	25	2.27
4	41	54	-13	169	3.13
Totals					5.87
				TR=	5.87
				CV (.05)(2df)	5.99

Potential Impact

While the recommendation above is an admittedly simple fix, potential benefits of developing an M+C option for NCQA accreditation are well worth the initiative and are outlined below:

A M+C supplement eliminates statistical differences between the models. This would facilitate debate on deeming legislation by providing policymakers the option to eliminate duplicate HMO oversight without the concern of compromising quality patient care and beneficiary protection.

Deeming legislation could result in cost savings to state governments. Since plans that choose to be evaluated under the M+C supplement would meet state requirements, less TDI audits would be performed. Based on the statistical analysis, TDI officials could provide a higher level of quality and beneficiary protection while performing less hands-on audits that require a significant number of state employees to conduct.

Deeming legislation could result in enhanced benefits for Medicare-eligible seniors. As mentioned earlier, eight Texas M+C HMOs spend approximately \$1.2M on accreditation and auditing fees. Of that, \$400,000 could be saved by eliminating the TDI audit requirement. This savings would be reflected on the ACR submitted to HCFA and would require plans to make up the difference with enhanced benefits.

Conclusion

This content analysis study compared the audit tools used by federal and state regulatory agencies with an industry-based HMO accreditation process. It examined the oversight models used by HCFA, TDI, and NCQA to determine if duplication exists among the agencies. After categorizing the inspection standards for each model, two nonparametric statistical tests were accomplished to check for differences in the distribution of items by major oversight category and in the method of evaluation used to determine compliance with the standards. Alpha for both tests was set at .05. The models differed significantly in the emphasis placed on the four oversight topics of finance, beneficiary protection and information, quality assessment and improvement, and plan management. In particular, the regulatory agencies devoted a higher percentage of their auditing tools to examining beneficiary marketing materials and the appeal/greivance process used by the HMO. The NCQA, on the other hand, focused more on quality improvement programs and in the activities involved in managing a health plan.

Industry-based accrediting organizations, such as the NCQA, were formed to meet the demands of health care purchasers by, among other things, ensuring the quality of health care provided and providing a forum to compare the performance of competing plans. Research suggests that the quality of care provided by organizations subjected to accreditation continues to improve. Both purchasers and plan members benefit as HMOs strive to improve their standing

on the highly competitive report cards. Some states have capitalized on the benefits of this competition. Currently, 37 states have passed some form of deeming legislation which allows HMOs to pursue industry-based accreditation to satisfy some or all of state oversight requirements. Texas, however, has not passed such legislation. Like its federal counterparts, TDI prepares to increase regulatory requirements and oversight on HMOs operating in the state.

This study recommends that the NCQA act to eliminate the current differences among the oversight models. Targeting HCFA's concerns regarding proper Medicare reimbursements and beneficiary protection in marketing materials, the NCQA should develop a M+C supplement to its current accreditation survey process. These additional items would eliminate the statistical differences found in the models and would allow lawmakers to pursue deeming legislation without the fear of sacrificing quality and beneficiary protection. Health plan participation would be voluntary since not all plans participate in the M+C program. A plan would notify NCQA that it wished to be examined under the M+C requirements at the time of application for accreditation.

In conclusion, the M+C program was designed to provide Medicare eligible seniors with a choice of health care options and, at the same time, capitalize on the potential for cost savings and preventive health culture inherent in managed care. These program goals have yet to be realized, however, and recent initiatives to revise the M+C payment methodology and expand regulation further jeopardize the M+C program. At a time of widespread HMO withdrawals from the M+C market, increases in health plan costs, and subsequent reductions in plan benefits to members, it is pertinent to examine all aspects of the M+C program for potential avenues to enhance system efficiencies. The reduction in multi-agency oversight for M+C plans is a critical first step in improving system performance in Texas. A M+C supplement to NCQA accreditation

would facilitate the debate for deeming legislation. If passed, deeming legislation would lead to reduced government oversight costs and lower administrative costs for health plans. As required by federal law, the reduction in administrative costs would be passed along in the form of additional plan benefits to the approximately 361,000 Texans participating in the M+C program.

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Appendix A
1999 Texas Health Care Legislation Affecting HMOs

Bill	Summary
S.B. 130	Prohibits an insurer or third party administrator (TPA) from reimbursing a provider on a discounted fee basis unless the insurer or TPA has contracted with the individual provider or a preferred provider organization that has a contract with the individual provider.
S.B. 445	Establishes the State Child Health Plan for uninsured children under the age of 19 who are not eligible for Medicaid and whose family incomes are below thresholds to be established by the Texas Health and Human Services Commission.
S.B. 569	Prohibits a utilization review agent (URA) from requiring the observation of a psychotherapy session or the submission of a mental health therapist's notes.
S.B. 781	Requires HMO and preferred provider contracts with podiatrists to require insurers or HMOs to furnish a copy of coding guidelines and payment schedules governing the podiatrist's compensation under the contract.
S.B. 881	Modifies enrollment period requirements for both large and small employer plans.
S.B. 890	Establishes a regulatory framework for use when HMOs delegate functions to organizations within its networks.
S.B. 982	Amends Texas Insurance Code Article 21.53G, which requires health plans that cover diabetes to pay for diabetes equipment, supplies and self-management training.
S.B. 1030	Adds new Texas Insurance Code Article 21.52J, concerning the use of prescription drug formularies by group health benefit plans. The bill requires disclosure to

enrollees that a formulary is used and how it works. A plan is required to disclose to an individual, upon request, whether a specific drug is on its formulary.

- S.B. 1084 Expands the Article 21.53 definitions of "employee benefit plan" and "health insurance policy" to include those providing dental care services--not merely dental care benefits in the event of accident or sickness.
- S.B. 1237 Brings pharmacy benefit managers under Texas Insurance Code Article 21.07-6, third-party administrators statute. Requires administrators of pharmacy benefit plans to provide enrollees with identification cards meeting standards issued by TDI.
- S.B. 1468 Establishes a mechanism for competing physicians to jointly negotiate with health plans on 16 different categories of contract terms and conditions. Joint negotiations generally may affect no more than 10 percent of the doctors in a service area. While joint negotiations are allowed, strikes or other joint withholding of health care services are not.
- S.B. 1884 Addresses independent reviews done at the request of a health plan sued for medical professional liability. The review must be performed in accordance with Texas Insurance Code Article 21.58C, which sets standards for independent review organizations.
- H.B. 213 Amends the Civil Practice and Remedies Code by requiring health care providers to bill patients on a timely basis and by barring recovery from patients when the timely billing requirement is not met.
- H.B. 610 Revises the statutes requiring prompt payment of preferred providers and HMO network providers. The bill defines "clean claim" as a completed claim, to be

further defined by TDI rules.

- H.B. 714 Requires health benefit plans that provide coverage for family members to pay for hearing loss screening tests for newborns and necessary diagnostic follow-ups through a child's first 24 months.
- H.B. 969 Requires most health plans providing benefits to children under 18 to define reconstructive surgery for craniofacial abnormalities to mean surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease. Small employer plans are exempt.
- H.B. 1211 Clarifies that HMOs may offer small employers any state-approved health benefit plan that complies with Texas Insurance Code Chapter 26 (the small employer statute), the Texas HMO Act, Title XIII of the federal Public Health Service Act and its subsequent amendments, and rules adopted under these laws.
- H.B. 1431 Authorizes the Commissioner to increase the Texas Health Insurance Risk Pool's payments to its administering insurer or TPA to as much as 15 percent of the pool's gross premium receipts in the current calendar year if necessary to cover the pool's administrative expenses.
- H.B. 1498 Requires, with exceptions, that large employer health plans include a point-of-service or other non-network option when the only coverage offered is through an HMO. Exceptions include small employer plans and group model HMOs that teach medical students under contract with a Texas state college or university.
- H.B. 1627 Requires an insurer's bid for a city employee health plan, including stop-loss coverage, to stand as the insurer's entire offer. An insurer may not change or limit

the terms of the coverage after the contract has been made.

- H.B. 1628 Requires insurers, HMOs and approved nonprofit health corporations holding competitively bid health care contracts with state agencies and political subdivisions to report certain information. The information includes claim experience of the governmental body and the dollar amount of each "large claim," as defined by that body, during the preceding year. Only aggregate claim information is required. Individuals covered by the plan cannot be identified. The data must be kept confidential and may be viewed or used only for contract bidding purposes.
- H.B. 1764 Includes reciprocal exchanges among the types of insurers whose health plans must pay for reconstructive surgery after a mastectomy. The bill requires this coverage to include surgery and reconstruction of both the affected and the non-affected breast to achieve a symmetrical appearance.
- H.B. 1924 Authorizes health insurers to inform their customers about the Texas Health Insurance Risk Pool and tell them how to get information for use in comparing their current coverage with the benefits offered by the pool. This notice must be in a manner prescribed by TDI.
- H.B. 2061 Requires health benefit plans that provide prescription drug coverage to pay for any FDA-approved drug--including a drug not on a plan's formulary--prescribed to treat an enrollee for a covered chronic, disabling or life-threatening illness if certain conditions are met.
- H.B. 2748 Requires HMOs to provide well-child care from birth. The coverage must comply with federal requirements as implemented by the Texas Department of Health.

HMOs also must cover immunization against rotavirus and any other childhood immunizations required by statute or rule.

H.B. 2969 Repeals the requirement that carriers certify each year whether they are offering small or large employer health benefit plans.

H.B. 3016 Requires utilization review agents to send notice of determinations to enrollees' providers of record in all cases. Requires adverse determination notices to include information about the complaint and appeal process.

H.B. 3021 Revises HMO complaint, appeal and review requirements to include provider complaints and makes these requirements consistent with those for utilization review agents.

Source: Texas Legislature On-line (<http://www.house.state.tx.us>)

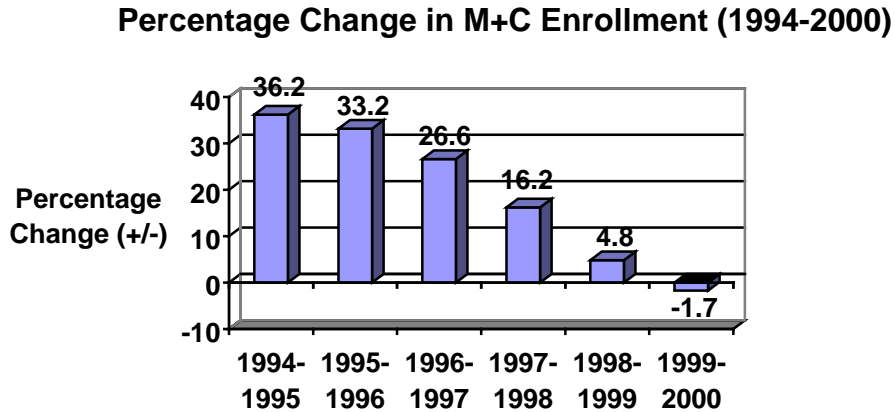
Appendix B
Computation of HMO M+C Payment Rates for 2000

Item	Percent	
	(-)	+
FFS Spending for an Average Medicare Beneficiary (starting point for MCO payments)		100.0%
Base Rate Reduction (basic effect of using only 95 percent FFS)	- 5.0%	
BBS Reductions in Growth Rate (effect of the annual reduction in the national per capita growth percentage from 1998 through 2002)	-1.7%	
Overpayments from HCFA Actuarial Assumptions and Calculations of 1997 Base Rates		+3.1%
Graduate Medical Education Carve-out	N/A	N/A
Risk Adjustment Factor (designed to recognize the health status of a plan's enrollees and more accurately reflect expected medical costs in MCO payment rates)	-0.6%	
Beneficiary Information Campaign User Fee (as an offset to monthly payments)	-0.3%	
Total Impact of Above when Compared with Average FFS spending	-4.5%	
Effective Payment Rate (percent of FFS): 0.5 percent above the base rate reduction		95.5%

Source: HHS Office of the Inspector General, 18 September 2000

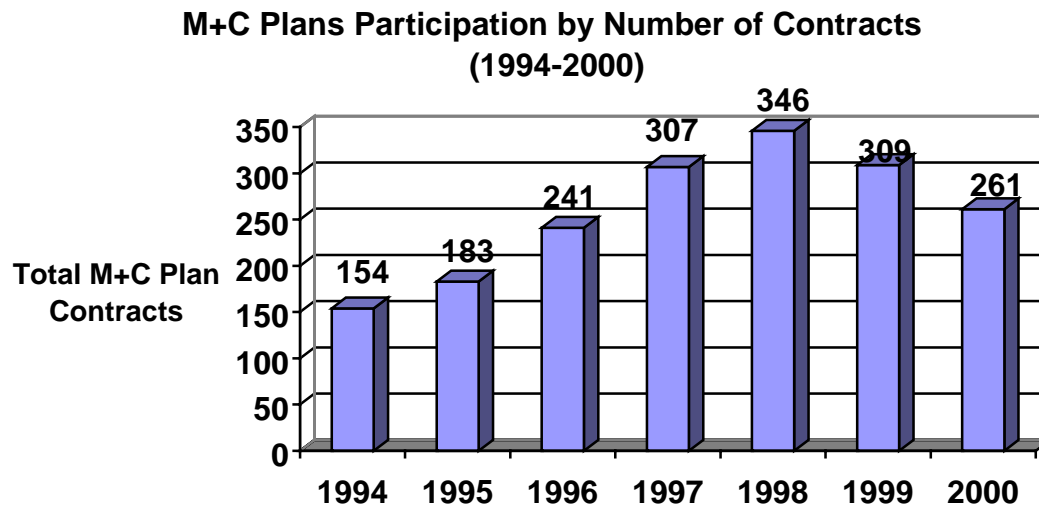
Appendix C
M+C Plan Participation and Beneficiary Enrollment Trends

Figure D1. Percent Change in Medicare+Choice Enrollment (1994 – 2000)



Source: AAHP analysis of HCFA Medicare Managed Care Contract Reports

Figure D2. Trend in Medicare+Choice Plan Participation (1994-2000)



Source: HCFA, Medicare Managed Care Contract Reports

Appendix D
HCFA Medicare Oversight Responsibilities and Reform Proposals

Source: “Medicare: 21st Century Challenges Prompt Fresh Thinking About Program’s Administrative Structure”; William J. Scanlon, Director of Health Financing and Public Health Issues, Government Accounting Office, testimony to U.S. Senate Finance Committee, May 4, 2000

Table E1

Medicare Oversight Responsibilities.

Program Activity	Example
Contractor Oversight	<p>HCFA’s central office and its regional offices—which also oversee the monitoring of nursing homes and other institutions—are responsible for monitoring the 50-some Medicare claims administration contractors. Among other things, HCFA staff must determine whether the contractors</p> <ul style="list-style-type: none"> - process most of their claims within a month or less of receipt - are not reversed on more than a small fraction of their claims decisions - generate correctly nearly all of their notices to beneficiaries explaining benefits - identify insurers that should have paid claims that were mistakenly billed to Medicare - operate fraud units that explore leads and develop and refer cases to law enforcement agencies

- identify instances or patterns of inappropriate billing that could result in unnecessary payments and serious financial losses to the program

Rate-setting

HCFA must set literally tens of thousands of payment rates to pay suppliers for Medicare-covered items and to pay providers—including hospitals, outpatient and nursing facilities, and home health agencies, among others—for Medicare-covered services. If Medicare's rates are set too high, taxpayers lose; if set too low, providers lose and beneficiary access is threatened. Following are examples of health care providers for which HCFA must establish Medicare payment rates and the analytical tasks involved:

- Physicians: Develop rates that reflect the resources involved in providing individual services as well as current practice costs in local markets
- Acute Care Hospitals: Update base rate and adjust payments to reflect inflation and geographic cost differences. Update patient classification mechanism that adjusts payments to reflect patient need.
- Home Health Agencies: Calculate base payments that reflect the average costs of an episode of home health care. Modify patient classification mechanism to better reflect patient need.

Medicare+Choice Plans: Set base price by estimating future growth in FFS spending. Refine methodology that adjusts the base rate to

	reflect an enrollee's higher or lower-than-average expected costs.
Consumer Information and Protection of Beneficiary Rights	<p>HCFA is responsible for providing beneficiaries with general information in regarding benefits and rights under the traditional program, Medicare supplemental insurance policies (Medigap), Medicare Select, and Medicare+Choice plans. As part of these responsibilities, HCFA must</p> <ul style="list-style-type: none"> - conduct an annual national educational and publicity campaign to inform beneficiaries about their Medicare options and the availability of Medicare+Choice plans in local areas - ensure the proper functioning of the process for appealing payment and coverage decisions - operate a toll-free hot-line to answer beneficiary questions - distribute comparative information on Medicare+Choice plans - review for accuracy the promotional literature and membership materials that each plan distributes to beneficiaries - ensure that plans have adequately informed beneficiaries of their right to appeal adverse coverage or payment decisions

Table E2

Comparison of Leading Medicare Reform Proposals in Addressing HCFA Management Problems.

HCFA Management	Medicare Modernization Act of	Senate Bill 1895
Issue	2000	(Breaux-Frist Proposal)
Management Focus	Medicare's administrative structure remains as it is today.	Establishes an independent Medicare Board to manage competition among plans; traditional Medicare would exist as one of the competing health plans. The proposal would divide Medicare into two parts: The Division of HCFA-Sponsored Plans would administer the traditional Medicare plan; the Division of Health Programs would carry out HCFA's other non-Medicare responsibilities. The Breaux-Frist proposal would create entities whose sole focus was the Medicare program.

Management Continuity	No change to current tenure policy of HCFA's leadership.	Longer-tenured leadership is partially addressed. Members of the Medicare Board would serve staggered 7-year terms; no mention of changes in the terms of the HCFA leadership.
Management Capacity	HCFA's administrative budget would continue to be set via the appropriations process. However, HCFA would likely be granted some new flexibility in personnel, contracting, and purchasing practices.	HCFA would develop, and initially submit to Congress for approval, an annual business plan which includes items such as proposed changes in provider payment rates, contracting provisions, or purchasing strategies. Upon congressional approval of the business plan, HCFA would no longer be subject to the annual appropriations process for its administrative expenses. Congress would review/approve the business plan until the year 2008. After that time, HCFA could implement its business

plan without explicit

congressional approval.

Appendix E
Voluntary Accrediting Organizations

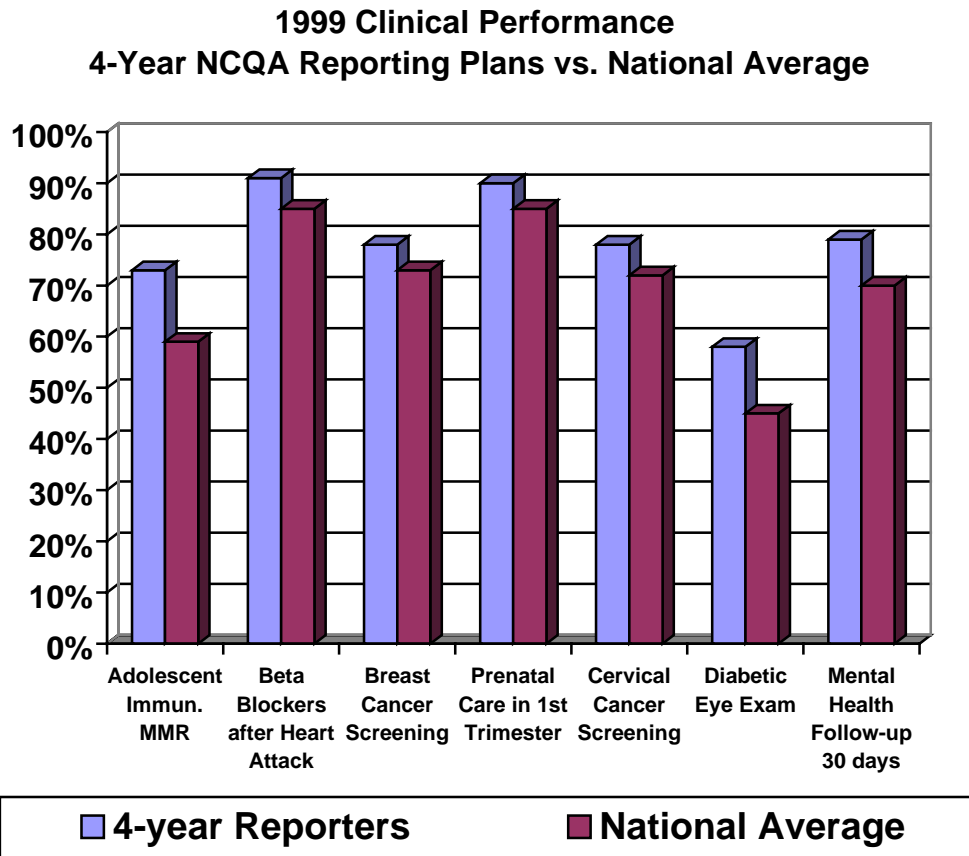
Source: American Association of Health Plans, 1999

Accrediting Organization	# Organizations		Types of Accreditation Programs
	1996	1999	
Accreditation Association for Ambulatory Health Care (AAAHC)	503	1086	<ul style="list-style-type: none"> • Ambulatory Care • Credentials Verification Organization
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)	6	53	<ul style="list-style-type: none"> • Ambulatory Care • Behavioral Health Care • Clinical Laboratories • Health Care Networks • Home Care • Hospitals • Long Term Care • Long Term Care Pharmacy • Managed Behavioral Health Care
National Committee on Quality Assurance (NCQA)	196	248	<ul style="list-style-type: none"> • Managed Care Organization • Managed Behavioral Health Care Organization

			<ul style="list-style-type: none"> • Credentials Verification Organization • Physician Organization • New Health Plan
American Accreditation Healthcare Commission (URAC)	151	512	<ul style="list-style-type: none"> • Health Utilization Management • Health Network • Health Plan • Health Care Practitioner Credentialing • Credentials Verification Organization • Workers' Compensation Utilization Management • Workers' Compensation Network • Health Care Call Centers • Case Management

Appendix F
Clinical Performance of Accredited Plans

Source: National Committee on Quality Assurance, 2000 State of Managed Care



Source: The State of Managed Care, 2000

Appendix G
Comparison of Oversight Models

Table G1

HCFA's Quality Improvement System for Managed Care Organizations (QISMC) Domain Standards.

Domain	Title	Remarks
1	Quality Assessment and Performance Improvement Program	Mandates requirements for the conduct of performance improvement projects.
2	Enrollee Rights	Addresses requirements such as written policies that detail the enrollees' rights to accessible and available services and the right to privacy.
3	Health Services Management	Requires that the M+C organization provide accessible and available services, an accessible provider network, and meet the complex (or chronic care) needs of individuals enrolled within the health plan, among other services.
4	Delegation	HCFA describes the standards that must be followed for the M+C organization to delegate services to external contracted vendors.

Source: American Association of Health Plans, 1999

Table G2

Elements of State Insurance Department Oversight Programs.

Element	Key Area(s)	Remarks
Licensure and Recertification	<ul style="list-style-type: none"> • Certificate of authority (COA). • Applications usually are processed by the insurance department • Fees usually required and about one-third of the states assess premium taxes against HMOs. 	Provides state officials with a mechanism to ensure that the HMO is operating properly and is in compliance with all the applicable laws and regulations.
Enrollee Information	<ul style="list-style-type: none"> • Enrollees are entitled to receive a copy of individual and group contracts. • Misleading, confusing, and unjust provisions are prohibited. • Each contract must contain basic information describing eligibility requirements, covered benefits, out-of-pocket expenses, limitations and exclusions, termination or cancellation of policies, claims processing, grievance procedures, 	Regulators require these documents to be filed with and approved by the regulatory body in charge of reviewing contracts.

continuation of benefits,
conversion rights, subrogation
rights, terms of coverage and grace
period after nonpayment of
premiums.

Access to Medical Services	<ul style="list-style-type: none"> • HMO patients should have access to medical care during reasonable hours; emergency care should be provided 24 hours a day, 7 days a week. • Protocols governing HMO specialty referrals 	Regulators limit an HMO's COA to designated service areas (usually established by ZIP code regions or counties) where a determination has been made that the HMO has a sufficient provider network.
Provider Issues	<ul style="list-style-type: none"> • HMOs are required to execute written contracts with participating providers. • Regulators review sample contracts (to include reimbursement formula) for primary care, specialty care, and ancillary services. • Contracts must contain a number of provisions, including a list of covered services, details about how 	Regulators scrutinize the reimbursement formulas to ensure that quality of care is not compromised and that provider solvency is not jeopardized.

physicians will be paid, hold-harmless language, the contract term, termination procedures, and an obligation to adhere to HMO quality assurance and utilization management programs.

Reports and Rate Filings	<ul style="list-style-type: none"> • HMOs must file an annual report to include audited financial statements, list of participating providers, update and summary of enrollee grievances handled during the year • Schedule of premium rates and methodology for determining rates 	<p>Regulators normally will approve the schedule or methodology if premiums are not excessive, inadequate, or unfairly discriminatory. In addition, states require HMOs to update regulators automatically if there are any changes in documents that were part of the initial COA application filing (or part of the annual filings).</p>
Quality Assurance and Utilization	<ul style="list-style-type: none"> • HMOs must file a description of their proposed quality assurance program before obtaining state 	<p>HMOs must also establish procedures to ensure that the health care services</p>

Review	<p>licensure.</p> <p>provided to their enrollees</p> <p>are “rendered under</p> <p>reasonable standards of</p> <p>quality of care consistent</p> <p>with prevailing</p> <p>professionally recognized</p> <p>standards of medical</p> <p>practice”. Some states</p> <p>require HMOs to obtain an</p> <p>independent external review</p> <p>of its quality assurance</p> <p>program from approved</p> <p>review agencies.</p>
Grievance Procedures	<ul style="list-style-type: none"> • HMOs must establish a grievance procedure to resolve enrollee complaints. • States often specify how these grievances should be handled. <p>The number of grievances filed and processed by an HMO is reported to the appropriate regulatory body.</p>
Solvency Protection	<ul style="list-style-type: none"> • Establishes specific capital, reserve, and deposit requirements • Requires a minimum deposit with the insurance department • Require HMOs to establish <p>If a regulator determines that an HMO’s financial condition threatens enrollees, creditors, or the general public, the regulator</p>

	contingency plans for insolvency that allow for the continuation of benefits to enrollees during the contract period for which premiums have been paid	can order the HMO to take specific corrective actions including reducing potential liabilities through reinsurance, suspending the volume of new business for a period of time, or increasing the HMO's capital and surplus contributions.
Financial Examinations and Site Visits	<ul style="list-style-type: none"> Specialized inquiries to examine HMO finances, marketing activities, and quality assurance programs 	The objective of these regulatory reviews is to determine the HMO's financial solvency and statutory compliance and whether any trends can be identified that may cause problems in the future.

Source: National Association of Insurance Commissioner's HMO Model Act (Carneal, 1997)

Table G4

Health Plan Employer Data and Information Set (HEDIS) Areas of Performance.

Element	Remarks
Effectiveness of Care	These measures assess how well the care delivered by a managed care plan is achieving the clinical results it should.
Satisfaction with the Experience of Care	These measures are intended to provide information about whether a health plan is able to satisfy the diverse needs of its members.
Cost of Care	These measures help consumers to estimate the stability of the health plan.
Informed Health Care	These measures help consumers to assess how their health plan has equipped them to make health care decisions.
Health Plan Descriptive Information	This section is a narrative of the attributes and operating characteristics of the health plan itself

Source: National Committee on Quality Assurance, 1999

Appendix H
Key Elements of Interest for Oversight Models

Major Element (includes)	Specific Elements of Oversight Model		
	HCFA's	NAIC's	NCQA's
	QISMC	HMO Model	HEDIS
Financial	Domain 3. Health	• Licensure	Cost of Care
• Health Care Costs	Services	• Financial	
• Plan Solvency	Management	Examinations	
• Provider		and Site Visits	
Reimbursement		• Annual Reports and Rate Filings	
		• Provider Issues	
Beneficiary	Domain 2. Enrollee	• Enrollee	• Satisfaction
Protection	Rights	Information	with
• Information		• Grievance	Experience of
• Grievances		Procedures	Care
			• Informed Health Care
Clinical Quality	• Domain 1.	Access to Medical	Effectiveness of
• Quality	Quality	Services	Care
Improvement	Assessment and		
• Quality	Performance		

Assessment

Improvement

- Availability of

- Domain 4.

Services

Delegation

Appendix I
Descriptive Statistics

Agency Models Before Analysis

Table I1(a)

HCFA's M+C Monitoring Guide.

Section	Title	# of Items	% of Total
1	Administration and Management	34	12.98%
2	EEO/ADA	1	0.38%
3	Fiscal Solvency/Insolvency Protection	2	0.76%
4	Incentive Arrangements	8	3.05%
5	Marketing	13	4.96%
6	Applications and Enrollment	21	8.02%
7	Membership	7	2.67%
8	Disenrollment	19	7.25%
9	Claims Processing	9	3.44%
10	Medicare Organizational Determinations and Appeals	16	6.11%
11	Internal Grievances	4	1.53%
12	QISMC Domain 1: QA and QI Programs	39	14.89%
13	QISMC Domain 2: Enrollee Rights	27	10.31%
14	QISMC Domain 3: Health Services Management	58	22.14%
15	QISMC Domain 3: Delegation	4	1.53%
Total		262	100%

Table II(b)

TDI's Quality Assurance Audit

Section	Title	# of Items	% of Total
1	Claims	14	3.47%
2	Complaints	39	9.68%
3	Contracts	18	4.47%
4	Credentialing/Recredentialing	68	16.87%
5	HMO Operations	7	1.74%
6	Member Services	37	9.18%
7	Network Accessibility and Availability	23	5.71%
8	Provider Manual	4	0.99%
9	Quality Improvement	91	22.58%
10	Single Service	12	2.98%
11	Utilization Management	90	22.33%
	Total	403	100%

Table II(c)

NCQA's Surveyor Guidelines for Accreditation

Section	Title	# of Items	% of Total
1	Quality Management and Improvement	133	30.30%
2	Utilization Management	97	22.10%
3	Credentialing and Recredentialing	76	17.31%
4	Members Rights' and Responsibilities	104	23.69%
5	Preventive Health Services	24	5.47%
6	Medical Records	5	1.14%
	Total	439	100%

Agency Models Categorized By Major Oversight Element

Table I2

Major Oversight Element Definitions

Element	Title	Definition
1	Financial	Item focuses on issues of plan costs, solvency, and/or
2	Beneficiary Protection	Item focuses on plan's efforts to communicate with its
	and Information	members as well as the grievance/appeal process, and
3	Quality Assessment	Item focuses on QI efforts in either the clinical or
	and Improvement	administrative arenas, clinical pathways or protocols,
		preventive health programs, customer satisfaction,
4	Plan Management	Item focuses on the established policies and
		procedures regarding oversight of plan management
		to include organizational structure and authority,
		resources available, reporting requirements,

Table I2(a)

HCFA's M+C Monitoring Guide

Element	Title	# of Items	% of Total
1	Financial	17	6.49%
2	Beneficiary Protection	119	45.42%
3	Clinical Quality	55	20.99%
4	Plan Mgmt	71	27.10%
	Total	262	100%

Table I2(b)

TDI's Quality Assurance Audit

Element	Title	# of Items	% of Total
1	Financial	4	0.99%
2	Beneficiary Protection	123	30.52%
3	Clinical Quality	65	16.13%
4	Plan Mgmt	211	52.36%
	Total	403	100%

Table I2(c)

NCQA's Surveyor Guidelines for Accreditation

Element	Title	# of Items	% of Total
1	Financial	2	0.46%
2	Beneficiary Protection	117	26.65%
3	Clinical Quality	94	21.41%
4	Plan Mgmt	226	51.48%
	Total	439	100%

Agency Models Categorized by Major Oversight Element and Method of Evaluation

Table I3

Method of Evaluation Codes Defined

Method	Definition
1	Interview with organizational personnel and/or review of internal documentation to include policy manuals, written procedures, medical
2	All items in 1 above <u>plus</u> review of all published materials to beneficiaries (marketing, Explanation of Benefits (EOB), disclosure/grievance/appeals

3 All items in 2 above plus review of documents submitted to external agencies

(HCFA, SEC/State financial filings, NCQA/HEDIS, etc.) and associated

Note. Codes are listed in rank-order with 1 considered the least stringent method of evaluation

and 3 considered the most stringent.

Table I3(a)

HCFA's M+C Monitoring Guide

		Method of	# of	% of	% of
Element	Title	Evaluation	Items	Element	Total
1	Financial	1	1	5.88%	0.38%
		2	2	11.76%	0.76%
		3	14	82.35%	5.34%
2	Beneficiary Protection	1	4	3.36%	1.53%
		2	95	79.83%	36.26%
		3	20	16.81%	7.63%
3	Quality Assessment & Improvement	1	30	54.55%	11.45%
		2	6	10.91%	2.29%
		3	19	34.55%	7.25%
4	Plan Management	1	14	19.72%	5.34%
		2	11	15.49%	4.20%
		3	46	64.79%	17.56%

Table I3(b)

TDI's Quality Assurance Audit

		Method of	# of	% of	% of
Element	Title	Evaluation	Items	Element	Total
1	Financial	1	1	25.00%	0.25%
		2	0	0.00%	0.00%
		3	3	75.00%	0.74%
2	Beneficiary Protection	1	14	11.38%	3.47%
		2	86	69.92%	21.34%
		3	23	18.70%	5.71%
3	Quality Assessment & Improvement	1	57	87.69%	14.14%
		2	0	0.00%	0.00%
		3	8	12.31%	1.99%
4	Plan Management	1	136	64.45%	33.75%
		2	7	3.32%	1.74%
		3	68	32.23%	16.87%

Table I3(c)

NCQA's Surveyor Guidelines for Accreditation

		Method of	# of	% of	% of
Element	Title	Evaluation	Items	Element	Total
1	Financial	1	2	100.00%	0.46%
		2	0	0.00%	0.00%
		3	0	0.00%	0.00%
2	Beneficiary Protection	1	17	14.53%	3.87%
		2	0	0.00%	0.00%
		3	100	85.47%	22.78%

3	Quality	1	31	32.98%	7.06%
	Assessment &	2	0	0.00%	0.00%
	Improvement	3	63	67.02%	14.35%
4	Plan Management	1	132	58.41%	30.07%
		2	0	0.00%	0.00%
		3	94	41.59%	21.41%

Appendix J
Listing of 100 Random Sample Inspection Items

Table J1

HCFA Sample Items

Record Number	HCFA Manual Reference		Variable	
	HCFA Item		Method of	Major Oversight
	Number	Section Number	Evaluation Code	Element Code
168	QH24	14	3	2
45	DS15	8	2	4
262	MK09	5	2	2
7	EN05	6	2	2
179	QH35	14	3	4
62	AP04	10	2	2
108	QI30	12	3	4
21	EN18	6	3	2
15	EN12	6	3	4
73	AP15	10	2	2
97	QI19	12	2	3
8	EN06	6	2	2
126	QR09	13	2	2
151	QH07	14	3	3
243	FS02	3	3	2
158	QH14	14	2	3

164	QH20	14	3	4
156	QH12	14	1	2
205	QD03	15	3	4
188	QH44	14	3	4
134	QR17	13	2	3
113	QI35	12	1	4
24	MB01	7	2	2
206	QD04	15	3	4
132	QR15	13	2	2
155	QH11	14	3	4
34	DS04	8	2	4
88	QI10	12	1	3
29	MB06	7	3	4
157	QH13	14	2	2
214	AM08	1	3	4
3	EN01	6	1	2
44	DS14	8	2	4
113	QI35	12	1	4
38	DS08	8	2	2
59	AP01	10	2	2
77	GR02a	11	2	2
178	QH34	14	1	3
242	FS01	3	3	1

244	IA01	4	2	2
80	QI02	12	3	3
233	AM10q	1	3	4
116	QI38	12	1	4
79	QI01	12	3	3
51	CP02	9	3	1
27	MB04	7	2	1
240	AM10x	1	3	4
220	Am10d	1	3	2
216	AM10	1	3	4
65	AP07	10	2	4
18	EN15	6	2	2
257	MK04	5	2	2
68	AP10	10	2	2
120	QR03	13	3	2
200	QH56	14	1	4
227	AM10k	1	3	2
129	QR12	13	2	2
162	QH18	14	1	3
245	IA02	4	2	2
194	QH50	14	1	3
96	QI18	12	3	3
124	QR07	13	2	2

166	QH22	14	3	2
145	QH01	14	2	2
39	DS09	8	2	2
126	QR09	13	2	2
235	AM10s	1	3	1
253	MK01a	5	2	2
177	QH33	14	1	3
50	CP01	9	3	1
114	QI36	12	1	4
2	MK11	5	2	2
20	EN17	6	2	2
228	AM10l	1	3	4
261	MK08	5	2	2
213	AM07	1	3	4
112	QI34	12	1	3
218	Am10b	1	3	4
199	QH55	14	2	4
75	GR01	11	2	2
28	MB05	7	3	4
3	EN01	6	1	2
238	AM10v	1	1	4
217	AM10a	1	3	4
255	MK02	5	2	2

234	AM10r	1	3	3
58	CP07	9	3	4
37	DS07	8	2	2
254	MK01b	5	2	2
30	MB07	7	2	4
119	QR02	13	3	4
182	QH38	14	3	4
161	QH17	14	1	3
191	QH47	14	1	3
146	QH02	14	3	2
93	QI15	12	3	3
167	QH23	14	3	2
43	DS13	8	2	2
260	MK07	5	2	2
8	EN06	6	2	2

Table J2

TDI Sample Items

Record Number	TDI Manual Reference		Variables	
	TDI	Section	Method of	Major Oversight
	Item	Number	Evaluation Code	Element Code
168	MS021	6	2	2
45	CO030	2	2	2
262	QI051	9	1	4
395	UM083	11	3	2
388	UM076	11	3	4
7	CL006	1	2	2
179	MS033	6	2	2
379	UM067	11	1	4
62	CN008	3	3	4
108	CR036	4	1	4
21	CO006	2	2	2
15	CL014	1	3	1
73	CR001	4	1	4
97	CR025	4	1	4
8	CL007	1	2	2
126	CR054	4	1	4
151	MS005	6	2	2
243	QI032	9	1	3

158	MS011	6	2	2
164	MS017	6	2	2
156	MS010	6	2	2
400	UM088	11	3	4
205	NA021	7	1	2
188	NA004	7	1	2
134	CR063	4	1	4
354	UM042	11	3	4
39	CO024	2	2	2
113	CR041	4	1	4
145	OP005	5	1	4
24	CO009	2	2	2
310	SS008	10	3	4
359	UM047	11	3	4
166	MS019	6	2	2
206	NA022	7	1	2
132	CR060	4	1	4
330	UM018	11	1	4
155	MS008	6	2	2
341	UM029	11	2	2
34	CO019	2	2	2
88	CR016	4	1	4
29	CO014	2	2	2

157	MS010	6	2	2
214	QI004	9	1	4
3	CL002	1	2	2
44	CO029	2	2	2
340	UM028	11	2	2
126	CR054	4	1	4
235	QI024	9	1	3
299	QI088	9	1	3
355	UM043	11	3	4
318	UM006	11	1	4
38	CO023	2	2	4
59	CN005	3	3	4
332	UM020	11	1	4
275	QI064	9	1	4
77	CR005	4	1	4
178	MS031	6	2	2
242	QI031	9	1	3
313	UM001	11	1	4
244	QI033	9	1	3
80	CR008	4	1	4
302	QI091	9	1	4
311	SS009	10	3	4
233	QI022	9	1	3

350	UM038	11	2	2
353	UM041	11	2	2
116	CR044	4	1	4
79	CR007	4	1	4
381	UM069	11	1	4
51	CO036	2	1	4
27	CO012	2	2	2
335	UM023	11	1	4
324	UM012	11	1	4
397	QI029	9	1	3
309	SS007	10	3	4
220	QI009	9	1	4
124	CR052	4	1	4
216	QI005	9	1	4
65	CN011	3	3	4
18	CO003	2	2	2
349	UM037	11	2	2
295	QI084	9	1	3
321	UM009	11	1	4
257	QI046	9	1	4
68	CN014	3	3	4
392	UM080	11	3	3
352	UM040	10	2	2

306	SS004	10	3	4
120	CR048	4	1	4
396	UM084	11	3	4
200	NA016	7	3	2
227	QI016	9	1	3
129	CR057	4	1	4
347	UM035	11	1	4
332	UM020	11	1	4
272	QI061	9	1	4
317	UM005	11	1	4
162	MS015	6	2	2
373	UM061	11	3	4
245	QI034	9	1	3

Table J3

NCQA Sample

Record Number	NCQA References			Variables	
	Item	Survey	Survey	Method of	Major Oversight
	Number	Section	Sub-section	Evaluation Code	Element Code
168	UM4.2	2	17	1	2
45	QI6.1.2	1	6	3	3
262	CR6.2	3	32	1	4
395	RR7.1	4	45	3	2

388	RR6.3	4	44	3	2
421	PH3.3	5	49	3	2
7	QI1.5	1	1	1	4
179	UM6.3	2	19	1	2
379	RR5.3.1	4	43	3	2
62	QI9.3	1	9	3	3
108	QI4.2.6	1	4	3	3
21	QI3.2.2	1	3	3	4
15	QI3.1	1	3	3	4
73	QI10.1.1	1	10	1	3
97	QI2.1	1	2	1	3
8	QI1.6	1	1	1	4
126	QI13.1.1	1	13	3	4
151	UM3.3	2	16	1	4
243	CR3.1	3	29	1	4
158	UM4.1.5	2	17	1	2
164	UM4.1.9	2	17	1	2
156	UM4.1.3	2	17	1	4
400	RR8.0	4	46	3	4
205	UM11.4	2	24	1	4
188	UM8.2	2	21	3	3
134	QI13.2.4	1	13	3	4
428	PH4.1.5	4	50	3	4

354	RR3.6.3.	4	41	3	2
	1.2				
435	MR1.0	6	51	1	4
113	QI4.3.4	1	4	3	3
418	PH3.0	5	49	3	2
24	QI5.1.1	1	5	3	4
310	RR1.2	4	39	3	2
359	RR3.6.3.	4	41	3	2
	6				
427	PH4.1.4	5	50	3	4
206	UM11.5	2	24	1	4
132	QI13.2.2	1	13	3	4
330	RR3.2.4.	4	41	1	2
	3				
155	UM4.1.2	2	17	1	4
341	RR3.4	4	41	3	2
34	QI5.2.4	1	5	3	4
88	QI11.2	1	11	1	3
29	QI5.1.6	1	5	3	4
157	UM4.1.4	2	17	1	4
214	UM12.2.	2	25	3	3
	2				
3	QI1.1	1	1	1	4

407	RR8.2	4	46	3	4
44	QI6.1.1	1	6	3	3
113	QI4.3.4	1	4	3	3
340	RR3.3.3.	4	41	3	2
	5				
299	CR12.1	3	38	3	4
355	RR3.6.3.	4	41	3	2
	2				
318	RR.3.1	4	41	3	2
38	QI5.3	1	5	3	3
59	QI9.2.2	1	9	3	3
332	RR3.3	4	41	3	2
275	CR7.5.2	3	33	1	4
77	QI10.2.1	1	10	1	3
178	UM6.2	2	19	1	2
242	CR3.0	3	29	1	4
313	RR1.5	4	39	3	2
244	CR3.2	3	29	1	4
80	QI10.3	1	10	1	3
426	PH4.1.3	5	50	3	4
302	CR12.1.3	3	38	3	4
233	CR1.2	3	27	1	4
350	RR3.6.2.	4	41	3	2

2					
353	RR3.6.3.	4	41	3	2
1.1					
116	QI7.1	1	7	3	3
79	QI10.2.3	1	10	1	3
381	RR5.4	4	43	3	2
51	QI6.4	1	6	3	3
27	QI5.1.4	1	5	3	4
335	RR3.3.3	4	41	3	4
324	RR3.2.1	4	41	3	2
433	PH4.2.4	5	50	3	4
406	RR8.1.5	4	46	3	4
397	RR7.2.1	4	45	3	2
240	CR1.9	2	27	1	4
220	UM13.1	2	26	3	4
297	CR11.5	3	37	1	4
216	UM12.4	2	25	3	4
65	QI9.4	1	9	3	3
18	QI3.1.3	1	3	3	4
349	RR3.6.2.	4	41	3	2
1					
295	CR11.3	3	37	1	4
321	RR3.1.3	4	41	3	2

257	CR5.1	3	31	1	4
68	QI9.5	1	9	3	2
392	RR6.7	4	44	3	2
352	RR3.6.3.	4	41	3	2
	1				
306	CR12.3.1	3	38	3	4
120	QI8.2	1	8	3	3
396	RR7.2	4	45	3	2
200	UM11.1	2	24	1	4
227	UM13.2.	2	26	3	4
	1				
129	QI13.1.4	1	13	3	4
347	RR3.6.1.	4	41	3	2
	3				
332	RR3.3	4	41	3	2
416	PH1.5	5	47	1	3

Appendix K
Wilcoxon Signed Rank Test Worksheets

Table K1

HCFA and NCQA (100 Pairs)

Pair	Method of		Method of		Computations			
	HCFA	Evaluation	NCQA	Evaluation	(N-O)	Signed Rank		
	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	QH24	3	UM4.2	1	-2	44		44
2	DS15	2	QI6.1.2	3	1	1	1	
3	MK09	2	CR6.2	1	-1	1		1
4	EN05	2	RR7.1	3	1	1	1	
5	QH35	3	RR6.3	3	0			
6	AP04	2	PH3.3	3	1	1	1	
7	QI30	3	QI1.5	1	-2	44		44
8	EN18	3	UM6.3	1	-2	44		44
9	EN12	3	RR5.3.1	3	0			
10	AP15	2	QI9.3	3	1	1	1	
11	QI19	2	QI4.2.6	3	1	1	1	
12	EN06	2	QI3.2.2	3	1	1	1	
13	QR09	2	QI3.1	3	1	1	1	
14	QH07	3	QI10.1.1	1	-2	44		44
15	FS02	3	QI2.1	1	-2	44		44

16	QH14	2	QI1.6	1	-1	1	1
17	QH20	3	QI13.1.1	3	0		
18	QH12	1	UM3.3	1	0		
19	QD03	3	CR3.1	1	-2	44	44
20	QH44	3	UM4.1.5	1	-2	44	44
21	QR17	2	UM4.1.9	1	-1	1	1
22	QI35	1	UM4.1.3	1	0		
23	MB01	2	RR8.0	3	1	1	1
24	QD04	3	UM11.4	1	-2	44	44
25	QR15	2	UM8.2	3	1	1	1
26	QH11	3	QI13.2.4	3	0		
27	DS04	2	PH4.1.5	3	1	1	1
28	QI10	1	RR3.6.3.	3	2	44	44
1.2							
29	MB06	3	MR1.0	1	-2	44	44
30	QH13	2	QI4.3.4	3	1	1	1
31	AM08	3	PH3.0	3	0		
32	EN01	1	QI5.1.1	3	2	44	44
33	DS14	2	RR1.2	3	1	1	1
34	QI35	1	RR3.6.3.	3	2	44	44
6							
35	DS08	2	PH4.1.4	3	1	1	1
36	AP01	2	UM11.5	1	-1	1	1

37	GR02a	2	QI13.2.2	3	1	1	1
38	QH34	1	RR3.2.4.	1	0		
			3				
39	FS01	3	UM4.1.2	1	-2	44	44
40	IA01	2	RR3.4	3	1	1	1
41	QI02	3	QI5.2.4	3	0		
42	AM10q	3	QI11.2	1	-2	44	44
43	QI38	1	QI5.1.6	3	2	44	44
44	QI01	3	UM4.1.4	1	-2	44	44
45	CP02	3	UM12.2.	3	0		
			2				
46	MB04	2	QI1.1	1	-1	1	1
47	AM10x	3	RR8.2	3	0		
48	Am10d	3	QI6.1.1	3	0		
49	AM10	3	QI4.3.4	3	0		
50	AP07	2	RR3.3.3.	3	1	1	1
			5				
51	EN15	2	CR12.1	3	1	1	1
52	MK04	2	RR3.6.3.	3	1	1	1
			2				
53	AP10	2	RR.3.1	3	1	1	1
54	QR03	3	QI5.3	3	0		
55	QH56	1	QI9.2.2	3	2	44	44

56	AM10k	3	RR3.3	3	0			
57	QR12	2	CR7.5.2	1	-1	1		1
58	QH18	1	QI10.2.1	1	0			
59	IA02	2	UM6.2	1	-1	1		1
60	QH50	1	CR3.0	1	0			
61	QI18	3	RR1.5	3	0			
62	QR07	2	CR3.2	1	-1	1		1
63	QH22	3	QI10.3	1	-2	44		44
64	QH01	2	PH4.1.3	3	1	1	1	
65	DS09	2	CR12.1.3	3	1	1	1	
66	QR09	2	CR1.2	1	-1	1		1
67	AM10s	3	RR3.6.2.	3	0			
			2					
68	MK01a	2	RR3.6.3.	3	1	1	1	
			1.1					
69	QH33	1	QI7.1	3	2	44	44	
70	CP01	3	QI10.2.3	1	-2	44		44
71	QI36	1	RR5.4	3	2	44	44	
72	MK11	2	QI6.4	3	1	1	1	
73	EN17	2	QI5.1.4	3	1	1	1	
74	AM10l	3	RR3.3.3	3	0			
75	MK08	2	RR3.2.1	3	1	1	1	
76	AM07	3	PH4.2.4	3	0			

77	QI34	1	RR8.1.5	3	2	44	44
78	Am10b	3	RR7.2.1	3	0		
79	QH55	2	CR1.9	1	-1	1	1
80	GR01	2	UM13.1	3	1	1	1
81	MB05	3	CR11.5	1	-2	44	44
82	EN01	1	UM12.4	3	2	44	44
83	AM10v	1	QI9.4	3	2	44	44
84	AM10a	3	QI3.1.3	3	0		
85	MK02	2	RR3.6.2.	3	1	1	1
			1				
86	AM10r	3	CR11.3	1	-2	44	44
87	CP07	3	RR3.1.3	3	0		
88	DS07	2	CR5.1	1	-1	1	1
89	MK01b	2	QI9.5	3	1	1	1
90	MB07	2	RR6.7	3	1	1	1
91	QR02	3	RR3.6.3.	3	0		
			1				
92	QH38	3	CR12.3.1	3	0		
93	QH17	1	QI8.2	3	2	44	44
94	QH47	1	RR7.2	3	2	44	44
95	QH02	3	UM11.1	1	-2	44	44
96	QI15	3	UM13.2.	3	0		
			1				

97	QH23	3	QI13.1.4	3	0			
98	DS13	2	RR3.6.1.	3	1	1	1	
			3					
99	MK07	2	RR3.3	3	1	1	1	
100	EN06	2	PH1.5	1	-1	1		1
							559	760
					# pairs	100		
					# of	28		
					Zeros			
					n=	72		
					T=	559		
					CV(.05)	907	(n-70)	

Table K2

TDI and NCQA (100 Pairs)

		Method of		Method of		Computations		
		TDI	Evaluation	NCQA	Evaluation	(N-O)	Signed Rank	
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	MS021	2	UM4.2	1	-1	1		1
2	CO030	2	QI6.1.2	3	1	1	1	
3	QI051	1	CR6.2	1	0			
4	UM083	3	RR7.1	3	0			

5	UM076	3	RR6.3	3	0		
6	CL006	2	PH3.3	3	1	1	1
7	MS033	2	QI1.5	1	-1	1	1
8	UM067	1	UM6.3	1	0		
9	CN008	3	RR5.3.1	3	0		
10	CR036	1	QI9.3	3	2	31	31
11	CO006	2	QI4.2.6	3	1	1	1
12	CL014	3	QI3.2.2	3	0		
13	CR001	1	QI3.1	3	2	31	31
14	CR025	1	QI10.1.	1	0		
			1				
15	CL007	2	QI2.1	1	-1	1	1
16	CR054	1	QI1.6	1	0		
17	MS005	2	QI13.1.	3	1	1	1
			1				
18	QI032	1	UM3.3	1	0		
19	MS011	2	CR3.1	1	-1	1	1
20	MS017	2	UM4.1.	1	-1	1	1
			5				
21	MS010	2	UM4.1.	1	-1	1	1
			9				
22	UM088	3	UM4.1.	1	-2	31	31
			3				

23	NA021	1	RR8.0	3	2	31	31
24	NA004	1	UM11.4	1	0		
25	CR063	1	UM8.2	3	2	31	31
26	UM042	3	QI13.2.	3	0		
			4				
27	CO024	2	PH4.1.5	3	1	1	1
28	CR041	1	RR3.6.3	3	2	31	31
			.1.2				
29	OP005	1	MR1.0	1	0		
30	CO009	2	QI4.3.4	3	1	1	1
31	SS008	3	PH3.0	3	0		
32	UM047	3	QI5.1.1	3	0		
33	MS019	2	RR1.2	3	1	1	1
34	NA022	1	RR3.6.3	3	2	31	31
			.6				
35	CR060	1	PH4.1.4	3	2	31	31
36	UM018	1	UM11.5	1	0		
37	MS008	2	QI13.2.	3	1	1	1
			2				
38	UM029	2	RR3.2.4	1	-1	1	1
			.3				
39	CO019	2	UM4.1.	1	-1	1	1
			2				

40	CR016	1	RR3.4	3	2	31	31
41	CO014	2	QI5.2.4	3	1	1	1
42	MS010	2	QI11.2	1	-1	1	1
43	QI004	1	QI5.1.6	3	2	31	31
44	CL002	2	UM4.1.	1	-1	1	1
			4				
45	CO029	2	UM12.2	3	1	1	1
			.2				
46	UM028	2	QI1.1	1	-1	1	1
47	CR054	1	RR8.2	3	2	31	31
48	QI024	1	QI6.1.1	3	2	31	31
49	QI088	1	QI4.3.4	3	2	31	31
50	UM043	3	RR3.3.3	3	0		
			.5				
51	UM006	1	CR12.1	3	2	31	31
52	CO023	2	RR3.6.3	3	1	1	1
			.2				
53	CN005	3	RR.3.1	3	0		
54	UM020	1	QI5.3	3	2	31	31
55	QI064	1	QI9.2.2	3	2	31	31
56	CR005	1	RR3.3	3	2	31	31
57	MS031	2	CR7.5.2	1	-1	1	1
58	QI031	1	QI10.2.	1	0		

			1				
59	UM001	1	UM6.2	1	0		
60	QI033	1	CR3.0	1	0		
61	CR008	1	RR1.5	3	2	31	31
62	QI091	1	CR3.2	1	0		
63	SS009	3	QI10.3	1	-2	31	31
64	QI022	1	PH4.1.3	3	2	31	31
65	UM038	2	CR12.1.	3	1	1	1
			3				
66	UM041	2	CR1.2	1	-1	1	1
67	CR044	1	RR3.6.2	3	2	31	31
			.2				
68	CR007	1	RR3.6.3	3	2	31	31
			.1.1				
69	UM069	1	QI7.1	3	2	31	31
70	CO036	1	QI10.2.	1	0		
			3				
71	CO012	2	RR5.4	3	1	1	1
72	UM023	1	QI6.4	3	2	31	31
73	UM012	1	QI5.1.4	3	2	31	31
74	QI029	1	RR3.3.3	3	2	31	31
75	SS007	3	RR3.2.1	3	0		
76	QI009	1	PH4.2.4	3	2	31	31

77	CR052	1	RR8.1.5	3	2	31	31
78	QI005	1	RR7.2.1	3	2	31	31
79	CN011	3	CR1.9	1	-2	31	31
80	CO003	2	UM13.1	3	1	1	1
81	UM037	2	CR11.5	1	-1	1	1
82	QI084	1	UM12.4	3	2	31	31
83	UM009	1	QI9.4	3	2	31	31
84	QI046	1	QI3.1.3	3	2	31	31
85	CN014	3	RR3.6.2	3	0		
			.1				
86	UM080	3	CR11.3	1	-2	31	31
87	UM040	2	RR3.1.3	3	1	1	1
88	SS004	3	CR5.1	1	-2	31	31
89	CR048	1	QI9.5	3	2	31	31
90	UM084	3	RR6.7	3	0		
91	NA016	3	RR3.6.3	3	0		
			.1				
92	QI016	1	CR12.3.	3	2	31	31
			1				
93	CR057	1	QI8.2	3	2	31	31
94	UM035	1	RR7.2	3	2	31	31
95	UM020	1	UM11.1	1	0		
96	QI061	1	UM13.2	3	2	31	31

			.1				
97	UM005	1	QI13.1.	3	2	31	31
			4				
98	MS015	2	RR3.6.1	3	1	1	1
			.3				
99	UM061	3	RR3.3	3	0		
100	QI034	1	PH1.5	1	0		
						1132	169
					# pairs	100	
					# of	29	
					Zeros		
					n=	71	
					T=	169	
					CV	907	(n=70)
					(.05)		

Table K3

HCFA and NCQA (by Major Oversight Element)

a. Major Oversight Element 2					Computations			
	HCFA	MOE	NCQA	MOE	(N-O)	Signed Rank		
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	QH24	3	UM4.2	1	-2	25		25
2	MK09	2	RR7.1	3	1	1	1	

3	EN05	2	RR6.3	3	1	1	1
4	AP04	2	PH3.3	3	1	1	1
5	EN18	3	UM6.3	1	-2	25	25
6	AP15	2	RR5.3.1	3	1	1	1
7	EN06	2	UM4.1.5	1	-1	1	1
8	QR09	2	UM4.1.9	1	-1	1	1
9	FS02	3	RR3.6.3.	3	0		
			1.2				
10	QH12	1	PH3.0	3	2	25	25
11	MB01	2	RR1.2	3	1	1	1
12	QR15	2	RR3.6.3.	3	1	1	1
			6				
13	QH13	2	RR3.2.4.	1	-1	1	1
			3				
14	EN01	1	RR3.4	3	2	25	25
15	DS08	2	RR3.3.3.	3	1	1	1
			5				
16	AP01	2	RR3.6.3.	3	1	1	1
			2				
17	GR02a	2	RR.3.1	3	1	1	1
18	IA01	2	RR3.3	3	1	1	1
19	Am10d	3	UM6.2	1	-2	25	25
20	EN15	2	RR1.5	3	1	1	1

21	MK04	2	RR3.6.2.	3	1	1	1
			2				
22	AP10	2	RR3.6.3.	3	1	1	1
			1.1				
23	QR03	3	RR5.4	3	0		
24	AM10k	3	RR3.2.1	3	0		
25	QR12	2	RR7.2.1	3	1	1	1
26	IA02	2	RR3.6.2.	3	1	1	1
			1				
27	QR07	2	RR3.1.3	3	1	1	1
28	QH22	3	QI9.5	3	0		
29	QH01	2	RR6.7	3	1	1	1
30	DS09	2	RR3.6.3.	3	1	1	1
			1				
31	QR09	2	RR7.2	3	1	1	1
32	MK01a	2	RR3.6.1.	3	1	1	1
			3				
33	MK11	2	RR3.3	3	1	1	1

71 78

pairs 33

of 0s 4

n= 29

T= 71

CV(.05) 126 (n=29)

b. Major Oversight Element 3						Computations		
	HCFA	MOE	NCQA	MOE	(N-O)	Signed Rank		
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	QI19	2	QI6.1.2	3	1	1	1	
2	QH07	3	QI9.3	3	0			
3	QH14	2	QI4.2.6	3	1	1	1	
4	QR17	2	QI10.1.1	1	-1	1		1
5	QI10	1	QI2.1	1	0			
6	QH34	1	UM8.2	3	2	4	4	
7	QI02	3	QI4.3.4	3	0			
8	QI01	3	QI11.2	1	-2	4		4
9	QH18	1	UM12.2.	3	2	4	4	
			2					
10	QH50	1	QI6.1.1	3	2	4	4	
11	QI18	3	QI4.3.4	3	0			
12	QH33	1	QI5.3	3	2	4	4	
13	QI34	1	QI9.2.2	3	2	4	4	
14	AM10r	3	QI10.2.1	1	-2	4		4
15	QH17	1	QI10.3	1	0			
16	QH47	1	QI7.1	3	2	4	4	
17	QI15	3	QI10.2.3	1	-2	4		4

	26	13
# pairs	17	
# of 0s	5	
n=	12	
T=	13	
CV(.05)	13	(n=12)

c. Major Oversight Element 4						Computations		
	HCFA	MOE	NCQA	MOE	(N-O)	Signed Rank		
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	DS15	2	CR6.2	1	-1	1		1
2	QH35	3	QI1.5	1	-2	7		7
3	QI30	3	QI3.2.2	3	0			
4	EN12	3	QI3.1	3	0			
5	QH20	3	QI1.6	1	-2	7		7
6	QD03	3	QI13.1.1	3	0			
7	QH44	3	UM3.3	1	-2	7		7
8	QI35	1	CR3.1	1	0			
9	QD04	3	UM4.1.3	1	-2	7		7
10	QH11	3	RR8.0	3	0			
11	DS04	2	UM11.4	1	-1	1		1
12	MB06	3	QI13.2.4	3	0			

13	AM08	3	PH4.1.5	3	0			
14	DS14	2	MR1.0	1	-1	1		1
15	QI35	1	QI5.1.1	3	2	7	7	
16	AM10q	3	PH4.1.4	3	0			
17	QI38	1	UM11.5	1	0			
18	AM10x	3	QI13.2.2	3	0			
19	AM10	3	UM4.1.2	1	-2	7		7
20	AP07	2	QI5.2.4	3	1	1	1	
21	QH56	1	QI5.1.6	3	2	7	7	
22	QI36	1	UM4.1.4	1	0			
23	AM10l	3	QI1.1	1	-2	7		7
24	AM07	3	RR8.2	3	0			
25	Am10b	3	CR12.1	3	0			
26	QH55	2	CR7.5.2	1	-1	1		1
27	MB05	3	CR3.0	1	-2	7		7
28	AM10v	1	CR3.2	1	0			
29	AM10a	3	PH4.1.3	3	0			
30	CP07	3	CR12.1.3	3	0			
31	MB07	2	CR1.2	1	-1	1		1
32	QR02	3	QI5.1.4	3	0			
33	QH38	3	RR3.3.3	3	0			

15 54

pairs 33

# of Os	18	
n=	15	
T=	15	
CV(.05)	25	(n=15)

Table K4

TDI and NCQA (by Major Oversight Element)

a. Major Oversight Element 2					Computations			
	TDI	MOE	NCQA	MOE	(N-O)	Signed Rank		
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	MS021	2	UM4.2	1	-1	1		1
2	CO030	2	RR7.1	3	1	1	1	
3	UM083	3	RR6.3	3	0			
4	CL006	2	PH3.3	3	1	1	1	
5	MS033	2	UM6.3	1	-1	1		1
6	CO006	2	RR5.3.1	3	1	1	1	
7	CL007	2	UM4.1.5	1	-1	1		1
8	MS005	2	UM4.1.9	1	-1	1		1
9	MS011	2	RR3.6.3.1.	3	1	1	1	
			2					
10	MS017	2	PH3.0	3	1	1	1	
11	MS010	2	RR1.2	3	1	1	1	
12	NA021	1	RR3.6.3.6	3	2	29	29	

pairs 33
 # of 0s 3
 n= 30
 T= 5
 CV(.05) 137 (n=30)

b. Major Oversight Element 3						Computations		
	TDI	MOE	NCQA	MOE	(N-O)	Signed Rank		
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	QI032	1	QI6.1.2	3	2	1	1	
2	QI024	1	QI9.3	3	2	1	1	
3	QI088	1	QI4.2.6	3	2	1	1	
4	QI031	1	QI10.1.1	1	0			
5	QI033	1	QI2.1	1	0			
6	QI022	1	UM8.2	3	2	1	1	
7	QI029	1	QI4.3.4	3	2	1	1	
8	QI084	1	QI11.2	1	0			
9	UM080	3	UM12.2.2	3	0			
10	QI016	1	QI6.1.1	3	2	1	1	
11	QI034	1	QI4.3.4	3	2	1	1	
							7	0

pairs 11
 # of 0s 4

n= 7

T= 0

CV(.05) 2 (n=7)

c. Major Oversight Element 4						Computations		
	TDI	MOE	NCQA	MOE	(N-O)	Signed Rank		
Pair	Item	(Original)	Item	(New)	Diff	Rank	Pos	Neg
1	QI051	1	CR6.2	1	0			
2	UM076	3	QI1.5	1	-2	2		2
3	UM067	1	QI3.2.2	3	2	2	2	
4	CN008	3	QI3.1	3	0			
5	CR036	1	QI1.6	1	0			
6	CR001	1	QI13.1.1	3	2	2	2	
7	CR025	1	UM3.3	1	0			
8	CR054	1	CR3.1	1	0			
9	UM088	3	UM4.1.3	1	-2	2		2
10	CR063	1	RR8.0	3	2	2	2	
11	UM042	3	UM11.4	1	-2	2		2
12	CR041	1	QI13.2.4	3	2	2	2	
13	OP005	1	PH4.1.5	3	2	2	2	
14	SS008	3	MR1.0	1	-2	2		2
15	UM047	3	QI5.1.1	3	0			
16	CR060	1	PH4.1.4	3	2	2	2	

17	UM018	1	UM11.5	1	0		
18	CR016	1	QI13.2.2	3	2	2	2
19	QI004	1	UM4.1.2	1	0		
20	CR054	1	QI5.2.4	3	2	2	2
21	UM043	3	QI5.1.6	3	0		
22	UM006	1	UM4.1.4	1	0		
23	CO023	2	QI1.1	1	-1	1	1
24	CN005	3	RR8.2	3	0		
25	UM020	1	CR12.1	3	2	2	2
26	QI064	1	CR7.5.2	1	0		
27	CR005	1	CR3.0	1	0		
28	UM001	1	CR3.2	1	0		
29	CR008	1	PH4.1.3	3	2	2	2
30	QI091	1	CR12.1.3	3	2	2	2
31	SS009	3	CR1.2	1	-2	2	2
32	CR044	1	QI5.1.4	3	2	2	2
33	CR007	1	RR3.3.3	3	2	2	2
34	UM069	1	PH4.2.4	3	2	2	2
35	CO036	1	RR8.1.5	3	2	2	2
36	UM023	1	CR1.9	1	0		
37	UM012	1	UM13.1	3	2	2	2
38	SS007	3	CR11.5	1	-2	2	2
39	QI009	1	UM12.4	3	2	2	2

40	CR052	1	QI3.1.3	3	2	2	2	
41	QI005	1	CR11.3	1	0			
42	CN011	3	CR5.1	1	-2	2		2
43	UM009	1	CR12.3.1	3	2	2	2	
44	QI046	1	UM11.1	1	0			
45	CN014	3	UM13.2.1	3	0			
46	SS004	3	QI13.1.4	3	0			

38 15

pairs 46

of 0s 19

n= 27

T= 15

CV(.05) 107 (n=27)

Attachment L
Proposed M+C Supplement to NCQA Survey

Table L1

Inspection Items for Financial Oversight Element

Source: HCFA's M+C Contractor Performance Measuring System, 1999

		Method of Evaluation
HCFA	Item	Code
Section	Number	Description of Standard
Administration and Management		
	AM10m	M+C organization's (M+CO) utilizing a physician incentive plan in their payment arrangements must meet the following requirements: specific payment, financial risk, stop-loss, and HCFA required information as defined in 422.210. The M+CO, through contract provisions informs all first-tier and downstream entities who contract with the M+CO of this requirement.
		3
	AM10n	All contracts between M+CO first-tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting entities
		3
	AM10s	The M+CO, provides notice to providers in writing of reason(s) for suspension and termination determinations
		3

that affect contracting physicians. The M+CO, through contract provisions informs all first-tier and downstream entities who contract with the M+CO of this requirement.

AM10t	The contract between the M+CO and providers requires that at least 60 days written notice be given to each other before terminating the contract without clause. The M+CO, through contract provisions informs all first-tier and downstream entities who contract with the M+CO of this requirement.	3
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Claims Processing

CP01	The M+CO assumes financial responsibility and provides reasonable reimbursement for emergency services, urgently needed services, post stabilization care as well as temporarily out of area renal dialysis services that Medicare enrollees obtain even without prior authorization.	3
CP02	The M+CO pays 95 percent of “clean” claims from unaffiliated providers within 30-days of receipt and provides payment in the amount the provider has billed, with maximum required payment to the provider being the amount the provider would have received under Original Medicare (including balance billing permitted under Medicare Part A and Part B). Payment of a clean claim constitutes an organizational determination. When clean	3

claims are paid in over 30 days, interest is computed and paid.

CP03	Contracts and other written agreements between M+CO and providers must contain a prompt payment provision. The payment terms of these contracts are agreed upon by the M+CO and relevant providers.	3
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Applications and Enrollment

EN19	The M+CO does not exceed the limitation (up to 90 days) which allows HCFA to retroactively adjust Medicare payments to the M+CP to cover the period of time the applicant enrolls through the Medicare Employer Group Health Plan (EGHP) and becomes eligible to receive services under the M+C contract, and the time the application is received by the M+CO and transmitted to HCFA.	3
EN20	For “working aged” M+CO enrollees who are employed by groups which are subject to Medicare Secondary Payer regulations, the M+CO only offers premium waiver (or premium reduction) if the enrollee maintains coverage through both the M+CO and the group product.	3

Fiscal Solvency/ Insolvency Protection

FS01	M+CO’s provide to HCFA such information as the Secretary may require demonstrating that the organization	3
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has a fiscally sound operation.

Incentive Arrangements

- | | | |
|-------|---|---|
| IA03 | The M+CO's incentive arrangements do not include any specific payment to be made directly or indirectly to a physician or physician group that will act as an inducement to withhold, limit, or reduce medically necessary services to an individual enrollee. | 3 |
| IA04b | If arrangements with any physician or physician group in the M+CO's network place a physician or physician group at substantial financial risk for services not directly provided (e.g. if there is a risk for referral services such as speciality, inpatient, outpatient, laboratory, or etc.), the M+CO provides or requires adequate and appropriate stop-loss protection for the physician/physician groups. | 3 |

Membership

- | | | |
|------|---|---|
| MB03 | The M+CO must agree to refund all amounts incorrectly collected from its Medicare enrollees, or from others who made payments on behalf of the enrollees, and to pay any other amounts due the enrollees or others on their behalf. | 2 |
| MB04 | The M+CO must make a single, lump-sum payment to each Medicare enrollee for amounts it owes under the following conditions if the M+CO is going out of business or is terminating its M+C contract: | 2 |

1) amounts incorrectly collected from enrollees that were not collected as premiums; 2) other amounts due enrollees (including prepayment of premiums, where the enrollee is terminated prior to exhaustion of prepaid premiums); and, 3) all amounts due enrollees of premiums or included premiums as well as other charges, the M+CO may refund by adjustment of future premiums or by a combination of premium adjustment and lump-sum payment.

QISMIC: Health Services Management

QH25	Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or or discontinuation of authorization of services.	3
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Table L2

Inspection Items for Beneficiary Protection and Information Element

			Method of Evaluation
HCFA	Item		Code
Section	Number	Description of Standard	(1, 2, or 3)

Administration and Management

AM10j	The M+CO adopts and maintains arrangements satisfactory to HCFA to protect its enrollees from incurring liability for	3
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payment of any fee that is the legal obligation of the M+CO (NAIC Hold harmless language or HCFA approved minor changes to NAIC language). The M+CO, through contract provisions informs all relevant first tier and down stream entities who contract with the M+CO of this requirement.

AM10k	<p>The M+CO provides for continuation of enrollee health benefits for the duration of the contract period and, for enrollees what are hospitalized on the date the HCFA contract ends, through the date of discharge. The M+CO has provisions and arrangements that protect beneficiaries from loss of benefits, in the event of insolvency. In instances where the M+CO chooses to provide protections by way of contract language, the M+CO, through contract provisions informs all relevant first tier and down stream entities who contract with the M+CO of this requirement.</p>	3
AM10w	<p>The M+CO, with respect to each M+C plan that it offers, requires that its providers adhere to the Medicare appeals and expedited appeals procedures for M+C enrollees, including gathering/forwarding information on appeals as necessary and as described in 422.564. If the M+CO delegates, the M+CO retains ultimate responsibility for</p>	3

ensuring that delegates adhere to HCFA guidelines. The M+CO, through contract provisions informs all relevant first tier and down stream entities who contract with the M+CO of this requirement.

Medicare Organization: Determinations and Appeals

AP06	<p>A written notice of a discontinuation of inpatient care (Notice of Discharge and Medicare Appeal Rights [NODMAR]) is provided to the enrollee whenever an enrollee is discharged from inpatient hospital care. The NODMAR must include: 1) reason why inpatient care is no longer needed; 2) the effective date of the enrollees risk of financial liability, and; 3) the enrollees appeal rights.</p>	2
AP16	<p>The M+CO complies with the requirement to disclose to beneficiaries upon request appropriate appeals data. The M+CO is required to collect and report information on:</p> <ol style="list-style-type: none"> 1) The time period covered 2) Total number of requests for an appeal by the M+C 3) Average number of enrollees in the organization 4) Total number of appeals per 1000 enrollees 5) Number of appeals completed during the submitted data collection period 6) Number of appeals decided fully in favor of the enrollee 	2

- 7) Number of appeals NOT decided fully in favor of the enrollee
- 8) Number of appeal requests withdrawn by the enrollee
- 9) Number of appeals sent to the independent review entity (IRE) for review (of the cases sent to the review entity)
 - a. Number of cases decided by IRE fully in favor of the enrollee
 - b. Number of cases NOT decided by IRE fully in favor of the enrollee
 - c. Number of cases withdrawn by the enrollee from the IRE
 - d. Number of cases awaiting decision by the IRE
- 10) The number of expedited appeal requests during the submitted data collection period
 - a. Number of expedited appeals granted
 - b. Number of expedited appeals NOT granted

Claims Processing

CP05	The M+CO must provide the enrollee of the right to appeal if it has failed to make a determination (adverse) within 60 calender days of receipt of the claim (ie. Failure to provide notice is deemed an adverse organization determination subject to appeal).	3
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Disenrollment

DS01	<p>The M+CO promptly disenrolls Medicare enrollees upon receipt of their written request (i.e. disenrollments are effective no earlier than the first day of the month following the month the M+CO receives the request.)</p> <p>Enrollees are not required to submit disenrollment requests within a specified time frame in advance of the desired date. Disenrollment requests accepted by the M+CO are signed and dated by Medicare enrollees. If the enrollee is unable to manage his/her affairs, a court-appointed guardian or other person authorized under state law may sign and date the disenrollment request.</p>	2
DS03	<p>The M+CO sends final notice to the enrollee confirming the date of disenrollment within five business days of receipt of the member's written request to disenroll. The letter includes the proposed effective date, a copy of the enrollee's written request to disenroll, and explains to the enrollee that neither the M+CO nor HCFA (Medicare) will pay for services not provided or arranged for by the M+C plan in which the enrollee is enrolled. The M+CO retains these disenrollment requests for six (6) years following the effective date of disenrollment.</p>	2
DS05	<p>Except for automatic disenrollments for death or loss of</p>	2

Part A or Part B, the M+CO notifies Medicare enrollees in writing of the intent to disenroll them, and mails such notices to enrollees before the effective date and prior to sending notice to HCFA. The notice contains the proposed effective date, a clear explanation of the reason for disenrollment, information on enrollee's right to a hearing under the M+CO's grievance procedure, and a reminder that the enrollee must receive services through the M+CO until the effective termination date.

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| DS06 | The M+CO may disenroll Medicare enrollees who fail to pay premiums only after sending a written notice of non-payment to the enrollee within 20 days after the date the premium was due. The effective date of disenrollment is the last day of the month in which the 90-day grace period ends. | 2 |
| DS07 | When an M+CO enrollee fails to pay his/her premium, the enrollee may convert to a standard benefit package provided by the same M+C plan (if available); however, such action may only be taken if the member has been notified in advance of the effective date of the conversion. | 2 |
| DS08 | Except as specified in 42 CFR 422.54, the M+CO disenrolls Medicare enrollees who leave the approved service area for more than 12 months, unless they move | 2 |

	(permanently) into an approved continuation area and the member has elected the continuation of enrollment option.	
DS09	The M+CO makes reasonable efforts to establish that Medicare enrollees have permanently moved from the approved service area. Such efforts are documented in writing or evidence exists in some other form acceptable to HCFA (as examples, official change of address notification, return mail stating “moved left no address”).	2
DS10	If offered by the M+CO in a specific M+C plan, a travel or visitor program must be offered to all enrollees who are members of the M+C plan (offering the visitor/travel program) who are temporarily absent from the service area and are temporarily residing in a geographic area served by an affiliated organization.	2
DS12	Medicare enrollees who are disenrolled for fraud or abuse are only disenrolled if they knowingly provide fraudulent information which materially affects the organization or affects the applicant’s eligibility to enroll or because an enrollee intentionally permits others to use the membership card to receive M+CO services.	2
DS13	The M+CO advises HCFA of such disenrollments only after reasonable advance notice is given to enrollees.	2
DS16	The M+CO disenrolls Medicare enrollees for disruptive	2

behavior only when their behavior is disruptive, unruly, abusive or uncooperative to the extent that continuing membership seriously impairs the M+CO's ability to furnish services to either the enrollee or other enrollees. Disruptive behavior includes threats of violence by the enrollee to employees of the M+CO.

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| DS17 | The M+CO disenrolls Medicare enrollees for disruptive behavior only after serious efforts to resolve the problem, including use of internal grievance procedures, consideration of extenuating circumstances, and HCFA's advance approval of the proposed disenrollment. | 2 |
| DS18 | The M+CO disenrolls enrollees effective the first day of the calendar month after the month in which notice is given to them of the intended action, unless an exception applies. | 2 |

Enrollment

- | | | |
|------|--|---|
| EN01 | The M+CO does not deny enrollment on the basis of health status except ESRD. | 1 |
| EN02 | The M+CO notifies enrollees of the denial within 30 days of receipt of the completed enrollment form. | 2 |
| EN03 | Enrollment applications are signed and dated by the enrollee or representative. | 2 |
| EN04 | The M+CO has documentation to establish that an applicant other than a beneficiary is authorized under state | 2 |

	law to make decisions related to health insurance election.	
EN05	Applications or acceptable facimiles (including scanned images stored on data files) are on file for all current enrollees and are kept for at least six (6) years following an enrollees disenrollment.	2
EN06	Applicants are given an opportunity to acknowledge that they understand the M+C plan's rules and agree to abide by them.	2
EN07	M+C plan applicants are informed through the application process that they may not be enrolled in more than one M+C plan at any given time.	2
EN08a	The M+CO must establish and maintain a system for confirming that enrolled beneficiaries have in fact, enrolled in the M+C plan and understand the rules applicable under the plan.	2
EN09	Prior to the "tentative" effective date (but not later than five business days after receipt of the completed election form), the M+CO notifies the applicant in writing of the receipt of the election form. The written notice of receipt specifies that effective date of enrollment, or, if the M+CO is currently enrolled to capacity, explains the procedures that will be followed when vacancies occur. M+Cos will have five business days from the receipt of the completed	2

election form to notify the applicant of the “tentative” effective date. (It is possible that if the M+CO receives the completed election form at the end of the month, the beneficiary may not receive the notification form prior to the tentative enrollment date. If the M+CO is able to document that the beneficiary notification was sent to the beneficiary within five business days after receipt of the completed election form, the M+CO has met this requirement).

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|------|--|---|
| EN10 | The M+CO provides evidence of health insurance coverage prior to the effective date of coverage, which may be in the form of a member card, a copy of the enrollment (election) form, and/or a letter to the member. | 2 |
| EN11 | The M+CO provides the applicant with a signed and dated copy of the application form. | 2 |
| EN13 | The M+CO must provide the applicant with a written explanation to deny an incomplete enrollment once 45 calendar days have passed since requesting additional documentation on an incomplete enrollment form, or to deny an enrollment based on the M+CO’s determination of the individual’s ineligibility to enroll. The M+CO must provide the applicant with a specific reason for the denial. | 2 |
| EN14 | When the M+CO receives enrollment confirmation from | 2 |

HCFA, it promptly (within seven business days of the availability of the Reply Listing) notifies enrollees in writing of the effective date of enrollment.

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|------|---|---|
| EN15 | When the M+CO is filled to capacity or closes enrollment, it notifies subsequent applicants in writing of the procedures that will be followed when enrollment reopens or vacancies occur. The procedures ensure that vacancies are filled in chronological order. | 2 |
| EN17 | The M+C plan offered by an M+CO must accept any individual (residing in the service area or continuation area of the M+C plan) who is enrolled in a health plan offered by the same M+CO (regardless of whether the individual has end-stage renal disease [ESRD] during the month immediately preceding the month in which he or she is entitled to both Part A and Part B as provided by CFR 422.50(a)(2) and (a)(3). | 2 |
| EN18 | The M+CO enrolls Medicare Employer Group Health Plan (EGHP) applicants who are enrollees of an employer group plan and certifies that it provided him/her with an explanation of enrollee rights, including the lock-in requirements. | 3 |

Fiscal Solvency/ Insolvency Protection

- | | | |
|------|--|---|
| FS02 | The M+CO protects beneficiary enrollees from incurring | 3 |
|------|--|---|

liability for payment of any fee that the M+CO is legally obligated to bear.

Membership

- | | | |
|------|--|---|
| MB01 | If the M+CO intends to change its rules for an M+C plan, it must give notice to all enrollees 30 days before the intended effective date of the changes. | 2 |
| MB02 | The M+CO does not make changes during the contract year which result in an increase in premiums or a decrease in benefits. If there is a mid-year regulatory change in Medicare program benefits, the M+CO notifies its enrollees of the added benefits. | 2 |

Marketing

- | | | |
|-------|---|---|
| MK01 | The M+CO offers plans to all Medicare-beneficiaries and provides adequate written descriptions of its rules, procedures, benefits, fees and other charges, services, and other necessary information for the beneficiary to make an informed decision about enrollment. | 2 |
| MK01a | The M+CO charges Medicare members only for deductible and coinsurance amounts for furnished covered services; non-covered services or services for which the enrollee is liable; and services for which Medicare is not the primary payer. | 2 |
| MK01b | The M+CO offers its plan(s) to all Medicare enrollees | 2 |

residing in the plan's service area at a uniform premium
and with a uniform level of cost-sharing.

- | | | |
|------|---|---|
| MK02 | The M+CO publicizes the annual election period

(November) and all enrollment periods, whether of limited

or continuous duration, through appropriate media,

throughout its service (and continuation) area. | 2 |
| MK03 | The M+CO must provide a current copy of their Evidence

of Coverage (EOC) that clearly describes members rights

and rules to enrollee (as defined by HCFA) at the time of

enrollment and annually thereafter. (Time of enrollment is

defined as the beneficiary receiving the EOS no later than

15 days after the effective enrollment date.) | 2 |
| MK04 | The M+CO demonstrates to HCFAs satisfaction that

marketing resources are allocated to marketing to the

disabled Medicare population as well as beneficiaries age

65 and over. | 2 |
| MK05 | M+CO may develop marketing materials designed for

members of an employer group who are eligible for

employer-sponsored benefits through the organization, and

to furnish these materials only to such group members.

Such materials must be submitted for HCFA approval of

the materials applicable to M+C plan benefits. | 2 |
| MK06 | The M+CO does not engage in activities which mislead, | 2 |

confuse, or misrepresent the M+CO: may not claim recommendation or endorsement by HCFA or that HCFA recommends that the person enroll in the organization; may not make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in HCFA-approved materials.

- | | | |
|------|---|---|
| MK07 | The M+CO does not offer gifts or payment as an inducement to enroll in the organization. | 2 |
| MK08 | The M+CO does not conduct door-to-door solicitation of Medicare beneficiaries. | 2 |
| MK09 | The M+CO submits all Medicare marketing materials including election forms (e.g. ads, brochures, enrollment and disenrollment notices, and other marketing material including those prepared by contracting third parties) to HCFA at least 45 days before their planned distribution. | 2 |
| MK10 | The M+CO does not distribute Medicare marketing materials if, before the expiration of the 45-day period, it receives written notice from HCFA that HCFA has disapproved the material because it is inaccurate or misleading or it misrepresents the organization, its marketing representative, or HCFA. | 2 |

MK11	The M+CO provides marketing materials in a format and using standard terminology as directed by HCFA.	2
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QISMIC: Health Services Management

QH01	The M+CO ensures that all covered services, including additional or supplemental services contracted for by or on behalf of Medicare or Medicaid enrollees, are available and accessible. [If the M+CO requested and HCFA approved a continuation area per CFR 422.54, Medicare-covered services in 422.101(a) are available in the continuation area to the extent required by 422.54(b)].	2
QH08	The M+CO ensures that the hours of operation of its providers are convenient to and do not discriminate against enrollees.	2
QH09	The M+CO ensures that services are provided in a culturally competent manner to all enrollees, including: those with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities.	2
QH10	An established M+CO seeking an expansion of its service area demonstrates that the numbers and types of providers available to enrollees are sufficient to meet the projected needs of the population and area to be served.	3

QISMIC: Enrollee Rights

QR05	The organization implements procedures to ensure that enrollees are not discriminated against in the delivery of health care services consistent with the benefits covered in their policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment. The M+CO ensures that it does not promote discrimination, discourage enrollment, steer specific subsets of enrollees to particular M+C plans or inhibit access to services.	2
QR06	Each enrollee has a right to accessible services. The organization ensures that all services, both clinical and non-clinical, are accessible to all enrollees, including those with limited English proficiency or reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities.	2
QR16	Enrollee information is available in the language(s) of the major population groups served and, as needed, in alternative formats for the visually impaired.	2

Table L3

Proposed Additions to NCQA Standards for Utilization Management:

			Method of Evaluation
HCFA	Item		Code
Section	Number	Description of Standard	(1, 2, or 3)
Administration and Management			
	Am10g	The M+CO has written standards for access to benefits in a manner described by HCFA. The M+CO, through contract provisions informs all relevant first tier and down stream entities who contract with the M+CO of this requirement.	3

Table L4

Proposed Additions to NCQA Standards for Preventive Health

			Method of Evaluation
HCFA	Item		Code
Section	Number	Description of Standard	(1, 2, or 3)
Administration and Management			
	AM10d	The M+CO does not inhibit access through self referral to screening mammography and influenza vaccine. The M+CO, through contract provisions informs all relevant first tier and down stream entities who contract with the	3

M+CO of this requirement.

AM10e	The M+CO does not impose cost-sharing for influenza vaccine and pneumococcal vaccine. The M+CO, through contract provisions informs all relevant first tier and downstream entities who contract with the M+CO of this requirement.	3
AM10f	The M+CO provides or arranges for direct access to in-network women's health specialist(s) for women for routine and preventive services. The M+CO, through contract provisions informs all relevant first tier and downstream entities who contract with the M+CO of this requirement.	3

Table L5

Proposed Additions to NCQA Standards for Credentialing and Recredentialing

			Method of Evaluation
HCFA Section	Item Number	Description of Standard	Code (1, 2, or 3)
Disenrollment			
	DS11	The M+CO has agreements in effect only with affiliated organizations which are contracting with HCFA to furnish the same services to its Medicare enrollees which the	3

M+CO itself would provide (at a minimum its basic benefit package) and is only offered to members who are temporarily absent from the M+CO's service area.

Table L6

Proposed Additions to NCQA Standards for Medical Records

		Method of Evaluation
HCFA	Item	Code
Section	Number	Description of Standard
		(1, 2, or 3)
QISMIC: Health Services Management		
	QH51	Enrollee health records are available and accessible to the M+CO and to appropriate state and federal authorities, or their delegates, involved in assessing the quality of care or investigating enrollee grievances or complaints.
		3

Appendix M
Listing of 100 Random Sample Items for NCQA/M+C Model

NCQA Reference				Variables	
Record	Item	Section	Sub-section	Method of	Major Oversight
Number	Number	Number	Number	Evaluation	Element Code
				Code	
339	RR3.3.3.5	4	41	3	2
10	QI1.7.2	1	1	1	4
281	CR8.3	3	34	1	4
108	QI4.3	1	4	3	4
379	RR5.3.2	4	43	3	2
193	UM10.1.1	2	23	1	4
515	AM10e	M+C Supp		3	2
218	UM13.0	2	26	3	4
513	Am10g	M+C Supp		3	2
21	QI5.0	1	5	3	4
120	QI8.3	1	8	3	3
162	UM4.1.8	2	17	1	4
358	RR3.6.3.6	4	41	3	2
191	UM10.0	2	23	1	4
164	UM4.1.10	2	17	1	2
404	RR8.1.4	4	46	3	4
155	UM4.1.3	2	17	1	4

500	MK06	M+C Supp		2	2
468	DS10	M+C Supp		2	2
473	DS18	M+C Supp		2	2
453	MB04	M+C Supp		2	1
75	QI10.2	1	10	1	3
30	QI5.2.1	1	5	3	4
101	QI4.1	1	4	3	3
317	RR.3.1	4	41	3	2
515	AM10e	M+C Supp		3	2
8	QI1.7	1	1	1	4
355	RR3.6.3.3	4	41	3	2
167	UM4.2	2	17	1	2
250	CR4.2	3	30	1	4
102	QI4.2.1	1	4	3	4
406	RR8.2	4	46	3	4
209	UM12.0	2	25	3	4
101	QI4.1	1	4	3	3
499	MK05	M+C Supp		2	2
249	CR4.1	3	30	1	4
60	QI9.2.4	1	9	3	3
75	QI10.2	1	10	1	3
205	UM11.5	2	24	1	4
381	RR5.4	4	43	3	2

307	RR1.0	4	39	3	4
185	UM8.0	2	21	3	3
322	RR3.2	4	41	3	2
505	MK11	M+C Supp		2	2
262	CR6.3	3	32	1	4
270	CR7.3	3	33	1	4
18	QI3.2	1	3	3	4
118	QI8.1	1	8	3	3
390	RR6.6	4	44	3	2
255	CR5.0	3	31	1	4
439	MR2.0	6	52	1	3
480	EN07	M+C Supp		2	2
75	QI10.2	1	10	1	3
486	EN14	M+C Supp		2	2
174	UM5.3	2	18	1	2
511	QR06	M+C Supp		2	2
204	UM11.4	2	24	1	4
467	DS09	M+C Supp		2	2
126	QI13.1.2	1	13	3	4
25	QI5.1.3	1	5	3	4
229	UM13.2.4	2	26	3	4
285	CR9.3	3	35	1	2
341	RR3.5	4	41	3	2

269	CR7.2	3	33	1	4
202	UM11.2	2	24	1	4
473	DS18	M+C Supp		2	2
489	EN18	M+C Supp		3	2
253	CR4.5	3	30	1	4
35	QI5.2.5.1	1	5	3	4
454	QH25	M+C Supp		3	1
451	IA04b	M+C Supp		3	1
452	MB03	M+C Supp		2	1
278	CR8.0	3	34	1	4
117	QI8.0	1	8	3	4
326	RR3.2.4	4	41	3	2
8	QI1.7	1	1	1	4
283	CR9.1	3	35	1	2
504	MK10	M+C Supp		2	2
460	CP05	M+C Supp		3	2
64	QI9.4	1	9	3	3
117	QI8.0	1	8	3	4
451	IA04b	M+C Supp		3	1
284	CR9.2	3	35	1	3
365	RR5.1.1	4	43	3	2
11	QI1.7.3	1	1	1	4
109	QI4.3.1	1	4	3	4

158	UM4.1.6	2	17	1	2
213	UM12.2.2	2	25	3	3
122	QI8.5	1	8	3	3
435	MR1.1	5	51	1	2
392	RR6.8	4	44	3	2
199	UM11.1	2	24	1	4
44	QI6.1.2	1	6	3	3
344	RR3.6.1.1	4	41	3	2
82	QI11.0	1	11	1	3
339	RR3.3.3.5	4	41	3	2
347	RR3.6.2	4	41	3	2
144	UM2.5	2	15	1	4
235	CR1.5	3	27	1	4
299	CR12.1.1	3	38	3	4
